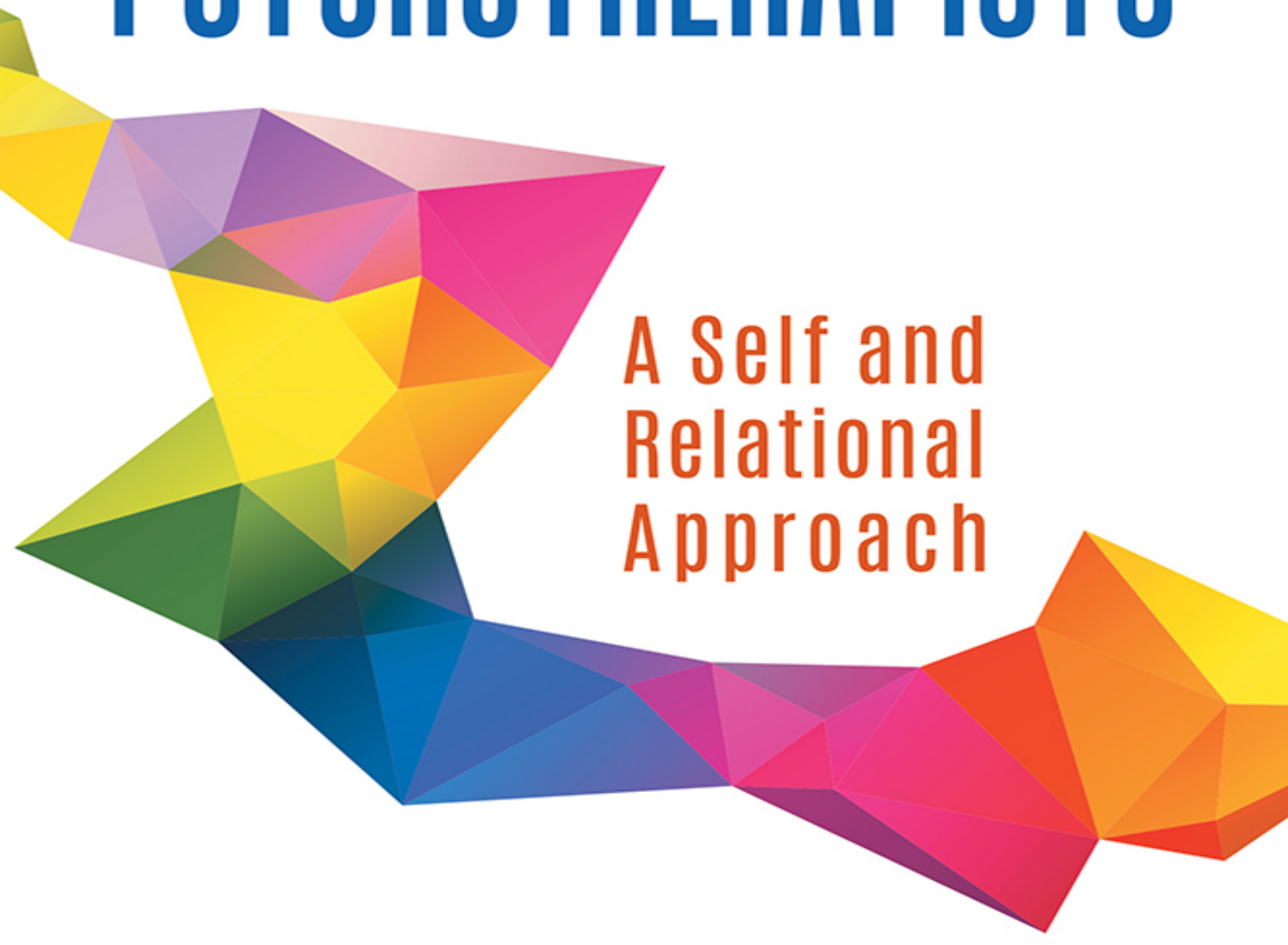
Practical Clinical Supervision for PSYCHOTHERAPISTS



A Self and Relational Approach

AUGUSTINE MEIER

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Dedicated to Peter Hawkins and Robin Shohet

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Supervising graduate students in counselling and psychotherapy was not something that the author had in mind when he began his career as a psychologist and university professor. However, Saint Paul University offered him a position to train and supervise the clinical practice of graduate students. When he began to supervise, the author gradually learned the art and science of supervision. The author wishes to express his appreciation to the graduate students who, with their diversity of personalities, needs, and struggles, contributed to his formation as a supervisor. The author also expresses his appreciation to the doctoral students in clinical psychology who sought to become certified as psychologists for bringing the art of supervision to another level through their advanced education, training, and clinical experience.

Over the past five years, the author has trained experienced psychotherapists to become clinical supervisors of graduate counselling students and of candidates who wish to register with a regulatory body. The clinical training was based on the contents of this book. The interaction with the experienced psychotherapists and the exchange of ideas from different theoretical orientations contributed to the honing of a supervision model that encompasses four dimensions including developmental, social role, competency, and process dimensions. The author wishes to express his appreciation to the participating psychotherapists for their insightful, challenging, and valuable contributions.

This book is dedicated to two professionals who had a significant influence upon the way the author thinks about and practices clinical supervision. Their thoughts about supervision and their approach to clinical supervision have had a lasting impact on the author. The author expresses his appreciation to the two professionals for their formative influence on his

growing appreciation for the value of supervision within the helping professions.

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INTRODUCTION

My abiding interest in clinical supervision began when I attended a day-long workshop on supervision by Peter Hawkins and Robin Shohet at the annual conference of the Society for Psychotherapy Research held in London, England over twenty-five years ago. On that day, I browsed the conference calendar of presentations. As there were none that caught my interest, I decided, out of self-interest, to attend Hawkins and Shohet's workshop on clinical supervision. I was very deeply impressed with their Process Model of Supervision which has remained the centrepiece of my approach to supervision.

The Process Model views clinical supervision from three perspectives. In the first perspective, the focus is on the client in terms of determining the client's concerns, conceptualizing the problem, and planning treatment. The second perspective focuses on the client and therapist relationship regarding the development of the therapeutic relationship and transferential and countertransferential issues. The third perspective focuses on the supervisee and supervisor relationship and addresses issues that may arise such as parallel processing. The Process Model comprises these three foci.

My first experience in providing clinical supervision was with graduate students in a counselling and psychotherapy program at Saint Paul University, Canada. Gradually, this supervision was extended to include doctoral level psychology graduates applying for Certification with the College of Psychology of Ontario and with seasoned counsellors and psychotherapists in private practice who wanted to grow professionally and personally.

Working with graduate students laid the foundation for my approach to clinical supervision. My commitment was to initiate the students into the

counselling profession, to help them to develop the required theoretical and practical skills, to grow in self-awareness, to develop the relational skills that provided a sense of safety and security for those seeking help, and to gain confidence as an effective helper. It became clear to me that providing clinical supervision did not follow a linear path but rather had many twists and turns. It also became clear that as a supervisor, I wore different hats depending upon the needs of the supervisee. At one time I might play the role of the teacher or instructor offering a conceptualization, directing how to implement a counselling technique, or pointing out the ethical and legal implications of their work. At another time I might assume the role of a counsellor and provide emotional support to the supervisee who might be questioning his suitability for the profession because of lack of progress in his therapeutic work. In working with graduate students, it became clear that not all students are at the same level in terms of their ability to conceptualize and plan treatment and in their degree of self-awareness and interpersonal skills. It became important that my supervision be tailored to the needs and developmental level of the supervisee.

Over the past decades, my approach which began with a focus on the supervision process (e.g., client-focused, therapist-client-focused) broadened to include a developmental dimension (e.g., beginning, intermediate, advanced supervisee); social role dimension (e.g., teacher, mentor, consultant); and competency dimension (e.g., models of supervision, legal and ethical foundations). The approach has been given the name of the Four-Dimensional (4-D) Model of Clinical Supervision.

My decades of experience as a supervisor naturally led to the next step which was to offer training for therapists and counsellors who wanted to become clinical supervisors. The first course and training in supervision was offered in 2013 and has been repeated in each of the following years. This book, in part, represents the approach and content of the supervision training.

Clinical supervision, as a topic of interest to researchers and authors, peaked during the 1980s and 1990s with little added since then (Watkins, 2012; Bernard & Goodyear, 2009). This era saw the development of supervision models, which were mostly stage models, and research on the development of supervisors. Most of the research, however, did not use any theoretical models of supervision when formulating their research design and questions (Barker & Hunsley, 2013). There is an agreement that to develop the field of supervision, new models of supervision are required, qualitative research is needed to provide substance to the supervisory experience, quantitative research is needed to test hypotheses, and new instruments are required to measure the development of supervisors. There is a critical need for empirical studies of psychotherapy supervisor development. Very little is known about the interior experience of the developing psychotherapy supervisor and even less is known about how a supervisor's internal life (e.g., cognitions, affect); skill level; and supervisory identity formation change as they acquire knowledge, training, supervision, and practical experience (Watkins, 2012). This research is yet to be done.

The purpose of this book is twofold. First, it summarizes the current theoretical literature and research on supervision. Second, it presents the Process Model of Clinical Supervision and demonstrates, through transcripts of supervision sessions, its three foci of supervision, namely client-focused, therapist-client-focused, and supervisee-supervisor-focused supervision. This book is unique in that it not only presents the current information about supervision, but it also, by including transcripts of the three foci of supervision, provides the reader with an opportunity to study the transcripts in detail and to use them as a model for self-development as a supervisor. In brief, the book provides information and at the same time offers the challenge of the formation of oneself as a supervisor.

This book is divided into three parts: Part One – Theoretical and Practical Aspects of Clinical Supervision; Part Two – Practice of Clinical Supervision; and Part Three – Research on Supervision. Part One comprises

chapters one to five, Part Two comprises chapters six and seven, and Part Three comprises chapter eight.

Part One summarizes the salient aspects of clinical supervision as presented by the major experts in the field. The first chapter presents the definition of supervision and its goals and functions. It is argued that supervision is a distinct intervention. Next, the topic of the supervisory relationship and the supervisor and supervisee factors that affect it are addressed. Lastly, the importance and benefits of clinical supervision are emphasized.

The models of supervision are presented in the second chapter. The models are grouped according to psychotherapy-based models, developmental models, social role models, and process models.

The third chapter presents the ethical and legal foundations of supervision. This chapter presents examples of codes of ethics and ethical decision-making models and addresses the specific application of a number of ethical domains to supervision.

The fourth chapter presents methods and interventions of clinical supervision. The methods are grouped according to concurrent methods, such as live observation and live supervision, and according to ex-post facto methods, such as process and case notes and audio and video recordings. Among the interventions and skills available to supervisors for the training of supervisees are systemic questioning, direct guidance, and homework.

The fifth chapter presents the process of evaluating supervisees in terms of the types of evaluation, the criteria for evaluation, and the conditions favourable for evaluation. This is followed by a discussion of the methods of evaluation, the major areas of evaluation, and communicating evaluation.

Part Two, Practice of Clinical Supervision, comprises chapters six and seven. The first of these two chapters focuses on the theoretical and practical aspects of supervision. The theoretical aspects include a brief presentation of the Self-in-Relationship Psychotherapy which guides the

demonstrations presented in chapter eight and an exposé of the Four-Dimensional (4-D) Model of Clinical Supervision. The practical aspects comprise the supervisor-supervisee contract and supervisor and supervisee tasks.

Chapter seven presents and demonstrates the Process Model of Supervision. The chapter begins with a brief description of the Process Model which comprises three foci, namely client-focused supervision, therapist-client-focused supervision, and supervisee-supervisor-focused supervision. For each focus, the supervisor-supervisee tasks, activities, interactions, and relational issues are presented and illustrated by transcripts of a role-played supervisory session.

Part Two, which comprises a single chapter, presents the results from research regarding different aspects of supervision. It is noted that there is a dearth of research on the development of supervisees from the beginning stage to the advanced stage and on the effectiveness of supervision and client outcome.

To make the text of this book more reader-friendly, the male form of third-person noun and pronoun are used in the odd-numbered chapters and the female form of third-person noun and pronoun are used in the even-numbered chapters.

PART ONE

Theoretical and Practical Aspects of Clinical Supervision

CHAPTER 1

Supervision Experience: Viewed from Within

This chapter presents clinical supervision as perceived and experienced from within by the supervisee and supervisor. It begins by providing the definition of clinical supervision, indicates how clinical supervision is different from administrative supervision, and argues that clinical supervision is a distinctive intervention. This is followed by a presentation of the goals and functions of supervision. The supervisory relationship and the factors that can affect its engagement are addressed. The chapter concludes by outlining the importance and benefits of clinical supervision.

Definition of supervision

Numerous definitions of clinical supervision have been offered which specify a range of functions and goals (Bordin, 1983; Holloway, 1995). In its simplest terms, clinical supervision can be considered a method of dialogue between a senior and a junior psychotherapist which influences the conduct (process) of psychotherapy. A distinction has also been made between administrative supervision and clinical supervision. The two roles might become conflicted and problematic when one person attempts to play both roles.

Administrative supervisor

An administrative supervisor is by definition someone who oversees or manages staff, such as clinicians, students, and support staff, in a bureaucratic organization (Holloway, 1995). The responsibilities of administrative supervisors are the correct, effective, and appropriate

implementation of agency policies and procedures. The administrative supervisor has been given authority by the agency to oversee the work of the supervisees. The primary goal is to ensure adherence to policy and procedure (Kadushin, 1992). When supervising a professional working in an organization, it is imperative that the clinical supervisor be aware of the policies and regulations of the institution and implement them when compatible with client care.

Clinical supervisor

Holloway (1995) defines clinical supervision as a learning alliance that enables the trainee to acquire skills and knowledge related to the profession and to experience interpersonal competence in the supervisory relationship. Inskipp and Proctor (2001) view supervision as a working alliance between two professionals where supervisees offer an account of their work, reflect on it, receive feedback, and receive guidance, if appropriate. The objective of this alliance is to enable the worker to grow in ethical competency, confidence, and creativity so as to give the best possible services to clients. Drapela (1983) defines clinical supervision as a process of overseeing, guiding, and evaluating professional activities for the purpose of ensuring a high quality of counselling services for the clients served (as cited in Aasheim, 2012, p. 5). Johnson (2007) describes clinical supervision as a relationship encompassing such varied roles as didactic expert, technical coach, therapist, role model, and evaluator demanding attention to quality control screening such that clients are provided with acceptable care which prevents supervisees from harming clients and refers those without sufficient skill or appropriate psychological fitness for remediation (p. 260).

The most frequently cited definition of supervision is the one coined by Bernard and Goodyear (2014) which has been informally adopted as a standard definition by the United States and the United Kingdom (p. 9). The authors define clinical supervision as:

> An intervention provided by a more senior member of a profession to more junior colleague or colleagues who typically (but not

> always) are members of that same profession. This relationship is evaluative and hierarchical, extends over time, and has the simultaneous purposes of enhancing the professional functioning of the more junior person(s), monitoring the quality of professional services offered to the client that she, he or they see; and serving as a gatekeeper for the particular profession the supervisee seeks to enter. (p. 9)

The most comprehensive and detailed model of supervision presented thus far is Milne's (2009) refinement of Bernard and Goodyear's (2004) widely cited work. Milne's description of supervision as cited by Aasheim (2012) is:

> The formal provision, by approved supervisors, of a relationship-based education and training that is work-focused and which manages, supports, develops, and evaluates the work of colleagues. It therefore differs from related activities, such as mentoring and therapy, by incorporating an evaluating component and by being obligatory. The main methods that supervisors use are corrective feedback of the supervisee's performance, teaching, and collaborative goal-setting. The objectives of supervision are 'normative' (e.g., case management and quality control issues), 'restorative' (e.g., encouraging emotional experiencing and processing), and 'formative' (e.g., maintaining and facilitating the supervisee's competence, capability, and general effectiveness). These objectives could be measured by current instruments. (p. 4)

The key concepts in this definition are that supervision is evaluative, hierarchical, and extends over time. Supervision is evaluative in the sense that the supervisor evaluates the supervisee's readiness to practice; the supervisee's competencies in terms of knowledge, intervention skills, and relational capacities; and the supervisee's ethical and professional conduct. The supervisor's evaluation is always in service of the well-being of the client.

The second key concept is that supervision is hierarchical. This is implied by the fact that supervision is evaluative; that is, the supervisor has interpersonal influence upon the supervisee.

The third key concept of supervision is that it extends over time. This distinguishes supervision from training and consultation, both of which might be brief and time-limited. The fact that supervision extends over time allows it to grow and develop. This is evident particularly when a supervisee moves from novice stage, into intermediate stage, and then on to advanced stage (Stoltenberg & Delworth, 1987).

In brief, supervision entails several elements: developing the supervisee's professional skills, supervisee gaining in self-awareness, protecting the client, and mentoring and evaluating the supervisee's services to clients. These elements are fostered within a learning alliance between supervisor and supervisee and are presented in greater detail throughout the book.

Supervision as a distinct intervention

Supervision is a distinct intervention. Though it draws on other interventions such as teaching, therapy, and consultation, supervision remains a unique intervention. There are similarities and differences between supervision and teaching, therapy, and consultation. These are outlined on Table 1.1 which has been adapted from Bernard and Goodyear (2014, p. 10). When comparing and contrasting supervision to teaching, therapy, and consultation, the parameters of comparison include being helpful, evaluating performance, the quality of relationship, and having a set agenda (i.e., a curriculum).

Importance and benefits of supervision

Given the above, what then are the importance and benefits of supervision? The suggestions below are based particularly on the practice of supervision.

The supervisor plays a “central, substantive and pivotal role in the whole of the supervisory process” which affects all aspects of the supervisee’s learning and growth and in turn affects the patient’s learning and growth (Watkins, 2012, p. 47). The supervisor’s level of development and commitment to supervision can have a far-reaching impact on the supervision experience and potentially affect the formation of the supervisory alliance, the use of in-session conceptualizations, and the strategies and outcomes experienced by supervisees and clients.

Supervision is essential to ensure high standards and excellent quality of professional practice. Effective supervision is essential for monitoring, improving, and advancing the field of psychotherapy. Ongoing supervision helps the supervisees to monitor and review the quality of their work and their client’s progress. Supervision is a form of professional self-regulation and is essential for the supervisee's right to be autonomous.

It is anticipated that by maintaining regular and quality clinical supervision sessions with qualified supervisors, supervisees will: (1) experience growth in self-awareness, skill, and knowledge; (2) be aware of and trained in best practices in their respective areas of service; (3) be evaluated regularly and given feedback on professional competency; (4) be more aware of ethical and legal requirements; (5) experience greater work satisfaction, health, and employment longevity; and (6) provide more effective, high quality service to clients.

Table 1.1

Supervision compared to teaching, therapy, and consultation

	Similarities	Differences
Teaching	1. Both have the purpose of imparting new skills and knowledge. 2. Both have evaluative and gate-keeping functions.	1. Teaching is driven by a set of curricula whereas supervision is driven by the needs of the supervisee and his/her clients.
Therapy	1. Both can address recipient's problematic thoughts, feelings, and behaviours.	1. Supervision is evaluative whereas therapy is not. 2. Any therapeutic work with a supervisee must be only to increase effectiveness with clients. 3. Therapy clients often have a greater choice of therapists than supervisees have of supervisors.
Consultation	1. Both are concerned with helping the recipient work more effectively and professionally. For more advanced trainees, the two functions may become indistinguishable.	1. Consultation is a relationship between equals, whereas supervision is hierarchical. 2. Consultation can be a one-time event, whereas supervision occurs across time. 3. Consultation is more usually freely sought by recipients than is supervision. 4. Supervision is evaluative, whereas consultation is not.

Adapted from Bernard and Goodyear, 2014, p. 10.

Goals of supervision

Bernard and Goodyear (2014) cite three goals of supervision which are to protect the welfare of the client by building and sustaining ethical practice, to develop and maintain the clinical competence of the supervisee, and to prepare the supervisee to self-supervise (pp. 13-14).

To these three goals, Aasheim (2012, p. 7) and Overholser (2004, p. 3) add the goals of developing professional identity and facilitating self-awareness and understanding on the part of the supervisee. Clark (2014) views the goals of supervision as "ensuring client welfare, enhancing supervisee growth within stages; promoting transition from stage to stage; evaluating the supervisee" (p. 3).

Two of the goals stated above appear to be dichotomous. For example, a university-based supervisor might give more attention to the teaching-learning goals whereas an on-site supervisor might give more attention to client-monitoring aspects. Feiner (1994) alluded to this dichotomy of goals when he wrote that some supervisors assume that their responsibility is to the student's client whereas other supervisors assume that their primary responsibility is to the development of the student. The implication is that in the first case, the focus is on the client; and in the second case, the focus is on the student. In reality, a supervisor pays attention to the welfare of both the supervisee and the client. Three goals of clinical supervision are described briefly below.

Protect the welfare of the client

The most basic goal of supervision entails protecting the welfare of the client by ensuring that the supervisees are engaging in sound ethical practices. The supervisor is responsible for ensuring that quality treatment is provided and no harm comes to the client.

The welfare of the client is best protected by helping supervisors develop principles of best professional practice. Good professional practice adheres to a sound understanding of ethical principles which implies that therapists fine-tune their awareness of process considerations and their decision-making in negotiating therapeutic change. Part of therapeutic work is how to treat a client and establish a relationship with the client. The Rogerian "core conditions" are as much about ethics of good counselling as they are about therapeutic methods. Rogers (1961) explains that "self-awareness, a recognition of process, an understanding of developmental needs and stages, and the empathic attunement to the client's reality and phenomenology of the self are crucial aspects of the therapy and carry their tremendous responsibility and opportunity" (p. 235). As well, good practice implies maximizing counsellor effectiveness by making the thinking about counselling explicit, thereby allowing for revisions to therapy (Rawson, 2003, p. 2).

An essential aspect of protecting the welfare of clients involves the monitoring of therapist skills, abilities, and limitations. Therapists should be capable of monitoring their services for potential risks, complications, and treatment failures (Overholser, 2004, p. 3). Clinical supervision affects the supervisee's level of ethical competence and in turn influences the quality of service to the client (Aasheim, 2012, p. 7).

Professional development of the supervisee

An essential component of training as a psychotherapist is for the supervisee to develop competence in the skills that are involved in providing psychotherapy. Supervisees should be encouraged to go beyond required trainings and seek out opportunities to build on existing skills and to expand their fund of knowledge in their respective areas of responsibility. Competence includes five primary domains: general knowledge of the field, generic clinical skills, specific technical skills, clinical judgment, and emotional maturity. Supervised experience is important to develop these

competencies. As well, it is important to learn how to properly conceptualize a client's problem.

Overholser and Fine (1990) suggest that the supervisor can foster the supervisee's development by carrying out the following tasks. The first task is to help the supervisee form a better and more integrated sense of the therapeutic process. This entails the therapist's capacity to be self-aware of his thoughts and feelings, the possibilities and limitations in psychological counselling, and personal and professional boundaries (Rawson, 2003, p. 1). This takes place in the interchange between therapist and client and manifests itself in the style, pacing, and art of therapy. The gaze turns inward. Brems (1999) proposes that the process of psychotherapy can be understood in terms of three separate but intervening circular processes, namely: (1) processing the relationship; (2) processing treatment challenges; and (3) understanding phases of change; that is, understanding how a client moves according to phases as they work through their concerns. Regarding the phases of change, Meier and Boivin (1998, 2000) and Meier, Boivin, and Meier (2006, 2008, 2010) developed the Seven-Phase Model of the Change Process as a way to track a client's movement from defining his concerns, to exploring its underlying dynamics and gaining insight, and then taking action and consolidating and integrating the behaviours and interactions that are congruent with the sense of self. Understanding the process of change is akin to having a guide or map which frees therapists to be flexible in the direction that they take (Walborn, 1996).

Second, a supervisor can help a therapist develop professional confidence and an increased ability to act autonomously in their work context. In addition to understanding the client's problem, effective supervision also helps the therapist to cope with their practice setting. This includes the therapist being free to consult those who are not front-line managers or in a training role. Hawkins and Shohet (1989) insist that supervision sessions should begin from exploring issues from their clinical practice and culminate with looking at where the supervisee will go next based on the

new work that has been explored. Thus, it is necessary to create a safe holding environment for the counsellor's concerns which enables the counsellor in the same way that they enable their own clients.

Third, the supervisor can help supervisees explore alternative means of understanding and intervening with particular client issues. In this regard, the supervisors can help supervisees develop an in-depth understanding of the client, facilitate appropriate goal setting, and acquire new skills and knowledge to improve their therapeutic work through goal-directed work. Supervisees can occasionally feel "stuck" with a particular client problem. Supervision can help a supervisee to see the problem differently and to re-affirm the basis of their therapeutic alliance (Rawson, 2003, pp. 2-3).

Fourth, supervisors can help supervisees develop their own unique therapeutic style by exploring the past and present experiences of therapeutic work. It is important for a therapist to develop his own style of therapy while at the same time remain genuine and meaningful to the client. It is important to guard against too wooden a style through too literal interpretation of concepts and procedures from the master therapists (Rennie, 1998). To be with a client implies that the therapist adapts his strategies to the client's readiness to work in the counselling relationship. This entails the counsellor inviting the client to work in certain ways and using feedback to direct the client through the process. It also involves the counsellor monitoring his own "reactions to client experience and … reflexivity in the moment-to-moment experience of counselling" (Rawson, 2003, p. 3).

Facilitating supervisee's self-awareness, self-development, and understanding

A third goal of supervision is to facilitate growth in self-awareness, self-development, and understanding on the part of the supervisee. While clinical supervision focuses on professional skills development, it also emphasizes growth in self-awareness and understanding on the part of supervisees. The Arizona Department of Health Services (2008) in its

practice protocol writes that "guiding the supervisee in greater self-awareness and self-care can increase the overall well-being of the clinician and, in turn, the quality of care to service recipients … Therefore, personal and professional development is also the responsibility of the clinical supervisor" (p. 4).

It is also important for the supervisor to pay attention to the supervisee's lived working realities. Supervisees face a number of challenges to their professional abilities and to their personal well-being. Increased caseloads and crisis situations can take their toll on supervisees. Consequently, clinical supervisors should monitor signs of "burnout" and work-related frustrations so that any related concerns may be detected and addressed early on. As well, the supervisors should teach supervisees to self-monitor in the areas of burnout, compassion fatigue, and impairment. Pearlman and Mac Ian (1995) note that one of the ten best ways to guard against burnout and impairment is regular, quality clinical supervision. Guiding the supervisee towards greater self-awareness and self-care as well as monitoring for signs of emotional stress and potential impairment can increase his overall well-being and, in turn, the quality of care provided to clients (Arizona Department of Health Services, 2008).

Functions of supervision

Supervision is intended to serve three related, but somewhat conflicting, functions, namely normative, restorative, and formative functions. These functions aim to implement the goals of supervision. Table 1.2 presents a summary of the tasks and goals of supervision based on Milne's (2009) definition of supervision.

Normative function

The normative functions entail monitoring and ensuring client well-being, and monitoring and evaluating supervisee competence (e.g., case management and quality control issues). The normative role includes two related aspects. First, supervisors have a responsibility to ensure that the

practice by their supervisees is conducted so as to benefit the clients of the psychological service, and that accepted standards of professional practice are adhered to. Second, the ultimate responsibility of supervisors is "to make a judgement about the core competencies of their supervisee . . . and whether they believe this person is sufficiently prepared to enter the profession as a colleague" (O'Donovan, Halford, & Walters, 2011, p. 102). That is, supervisors are gatekeepers ensuring that supervisees can practice the profession of psychotherapy competently.

Restorative function

The restorative functions entail supporting the supervisee's personal and professional well-being by encouraging emotional experiencing and processing. The restorative function of supervision focuses upon the support of the supervisee by the supervisor which is considered to be crucial to effective supervision. The field of positive psychology has been suggested as helpful in the restoration of well-being of supervisees. Positive psychology may contribute by assisting supervisees with increasing self-efficacy, increasing engagement with their work, and enhancing resilience (O'Donovan et al., 2011, p. 103).

Formative function

The formative functions include educating and guiding the supervisee's professional practice and maintaining and facilitating the supervisee's competence, capability, and general effectiveness (Milne, 2009, p. 15). The formative function of supervision entails the teaching role of enhancing the supervisee's knowledge and skills in the practice of psychotherapy.

Supervisees view the learning gained through supervision as the most helpful mode of learning in their development as psychotherapists (O'Donovan et al., 2011, p. 103).

The restorative and normative functions can be in tension with one other. The restorative functions require that the supervisor be an understanding educator and an empathic advocate for the supervisees, whereas the

normative function requires that supervisors enforce the required professional standards which can mean not supporting the supervisee. The tension between these functions creates a dilemma for both supervisees and supervisors (O'Donovan et al., 2011).

Supervisors need to learn how to manage the tension between the three functions of supervision, namely the normative, restorative, and formative functions. The following procedures can help to manage these tensions. First, supervisors need to make clear at the beginning of supervision the types of behaviours that are considered unethical or unprofessional and the steps that they would take if such behaviours occurred (Vacha-Haase, Davenport, & Kerewsky, 2004). This provides the supervisee with a clear understanding of the scope of acceptable practice which might reduce the supervisee's anxiety by disclosing information that does not exceed these bounds (O'Donovan et al., 2011). Second, in supervising supervisees who are in training, the supervisor needs the training institutions to acknowledge the difficulties that a supervisor might experience in their normative function and ensure that appropriate means are in place to support them in their function. This could include the use of standard tests, the use of clear guidelines when supervisees are underperforming, and the provision of corrective feedback (Bogo, Regehr, Power, & Regehr, 2007).

Table 1.2
Tasks and goals of supervision

Tasks	Immediate Goals	Ultimate Goals
Normative Case management, monitoring, and quality control Evaluate supervisee's performance	Trainee's therapy delivery is safe, ethical, and effective Enhance current clients' benefits Evaluate adequacy of supervisee's competence	Determine the supervisee's fitness for practice Ensure that the supervisee can independently practice safe and effective therapy
Restorative Emotional support and processing Enhance effective professional self-care	Develop supervisee's professional identity Enhance supervisee's professional resilience	Enhance supervisee's capacity to practice in ways that enhance his own health and prevent burnout
Formative Develop supervisee's skills and knowledge Assist clinical decision-making Promote supervisee's self-evaluation	Develop adequate repertoire of clinical knowledge and skills Enhance self-reflection skills	Develop long-term commitment and self-educational strategies to promote effective and evidence-based practice

Adapted from Milne, 2009.

Supervisory relationship and enlivening principles

For supervision to be effective and meaningful, it is important for the supervisor to establish a safe, supportive, and caring relationship. Both the supervisor and the supervisee need to be engaged in the supervision tasks so as to keep it a valuable, enlivened, and meaningful experience.

The supervisory relationship

The supervisory working relationship (alliance) is considered to be the context within which learning occurs, and it is observed to have a critical impact on whether supervision is effective. The quality of the working alliance predicts how effectively problems will be resolved and the overall progress of the supervisee.

The working alliance is considered to be of particular importance to achieve the restorative and formative functions of supervision. With respect to the restorative function, the supervisory alliance, particularly empathy by the supervisor, provides the context within which the supervisee self-discloses. It is also thought that a "strong supervisory alliance parallels, models, and promotes the crucial components of an effective therapeutic alliance between the supervisee and the client" (O'Donovan et al., 2011, p. 105).

The supervisor needs to be on guard so as not to develop a dual relationship. The potential for this exists since the supervisor both evaluates the supervisee on the normative functions and at the same time encourages the supervisee to be open and free to discuss emotions related to the work with the client. A dual role can be avoided, or at least minimized, when both the supervisor and supervisee understand that all three functions are part of supervision and that each function will be treated with the same degree of respect and care.

Principles that enliven supervision process and outcome

Watkins et al. (2014) list three foundational principles that enliven and impact supervisory process and outcome, namely "eminent valuation, abiding fidelity, and relational privilege" (p. 5). These three principles, collectively, can be viewed as reflecting a "fundamental supervisor attitude of caring, prizing, and generativity with regards to the whole of supervision" (p. 5).

The principle of eminent valuation is “to supremely value and respect” (Watkins et al., 2014, p. 5). Eminent valuation refers to the supervisor’s “assigning the highest value to supervision as a crucial educational experience and acting accordingly in deed” (p. 5). The effective supervisor values supervision’s unmatched power and promise in stimulating the development of the therapist. The supervisors readily give their utmost respect to supervision in being prepared, being on time, and treating supervision as sacred time; they fully invest their energy, emotion, and intellect while constantly asking the question – how can I best help this supervisee now?

The principle of abiding fidelity is “to be studiously loyal and committed” (Watkins et al., 2014, p. 6). It is the supervisor’s “full, complete, active commitment to supervision and personal continuing development as a supervision professional” (p. 6). The supervisor is passionately faithful to make supervision a best practices endeavour. The supervisor also shows direct faithfulness to the supervisee and communicates a sense of protection and preservation towards them by words such as “we will work tirelessly together for your maximal benefit” (p. 7).

The principle of relational privilege is to “supremely privilege and esteem” (Watkins et al., 2014, p. 5). This principle refers to “the supervisor’s highest privileging of the supervisor-supervisee relationship and assigning it preeminent value as a crucial mechanism in making the totality of supervision work” (p. 7). The supervisor-supervisee relationship is to be considered a “sacred trust” (Watkins et al., 2014, p. 7).

Desirable qualities of supervisors and supervisees

The desirable qualities of a supervisor and of a supervisee have been presented by Clark (2014), Kaufman and Schwartz (2003), and Watkins et al. (2014). These qualities come directly from supervisees and supervisors.

The ideal supervisor as described by supervisees possesses appropriate levels of empathy, genuineness, and courage; the ability to understand; a sense of humour; a capacity for intimacy; consideration for others; a positive outlook (optimism); a capacity for self-disclosure (openness); a sense of timing; and fantasy and imagery. In addition, the ideal supervisor's behaviour should encourage the supervisee to be honest about his interactions with the client, admit to mistakes so as to grow as a professional, and feel sufficiently comfortable to take risks (Clark, 2014; Kaufman & Schwartz, 2003, p. 148).

Supervisors have their expectations of supervisees. The characteristics of these expectations include interest in the welfare of the client, preparation for supervision, knowledge, self-awareness, openness to feedback, management of boundaries, self-disclosure, and an ability to make decisions. When the supervisee is competent in skills (e.g., assessment, treatment), possesses a theoretical identity, and has knowledge of ethics and professional behaviour, then the supervision session can become more conceptual and more process- or issue-oriented (Kaufman & Schwartz, 2003, p. 148).

Factors that may negatively affect engagement in the supervisory relationship

The factors that affect the engagement of the supervisee and the supervisor in the supervisory relationship (alliance) are briefly presented. Supervisee transference and supervisor countertransference are presented in greater detail in chapter seven.

Supervisee factors

This section presents and discusses supervisee factors and dynamics that affect their level of engagement with the supervisory relationship. These include supervisee resistance, attachment style, shame, anxiety, need to feel competent, and transference (Bernard & Goodyear, 2014; Friedlander & Shaffer, 2014).

Resistance

Resistance can mean resisting the supervisor's influence, the supervisory experience itself (can be reflected in parallel processing with the supervisee unconsciously assuming the position of the client), noncompliance with tasks related to the supervisory process, and noncompliance with mutually agreed upon plans with respect to the clients. The resistance could be related to the level of trust in the supervisor, the level of agreement about tasks and goals, the supervisee's developmental level, the supervisee's countertransference and parallel processing, and the supervisor's style.

Supervisee attachment style

The supervisee might have a learned attachment style of dependency and thus seeks advice from the supervisor. Alternatively, he might have learned the attachment style of avoidance and not accept the supervisor's suggestions. When this occurs, the supervisor explores with the supervisee what is happening between the two at the moment.

Supervisee shame

Supervision, because of its evaluative nature, involves the supervisee exposing his work and feeling exposed. As a result, the supervisee is prone to feelings of shame and guilt. When the supervisee experiences shame, he is predisposed to respond to it either in a passive and withdrawn way, a passive avoidant way, or an aggressive way (e.g., attack on others). It is incumbent on the supervisor to minimize supervisee's shame by creating a climate of trust and respect so that it allows the supervisee to develop security and dignity and to enable him to look at his secret failures that he otherwise would be afraid to admit. As well, the supervisor needs to learn how to provide performance feedback in ways that are least likely to evoke the feeling of shame. The supervisor can also reinforce the idea that mistakes are often made but what is important is to know how to repair them and to learn from them.

Supervisee anxiety

Research demonstrates that even the best of supervisees experience anxiety as therapists; this anxiety is expressed in multiple ways, and it affects the supervisee in different ways.

First, anxiety affects supervisee learning. Too much anxiety affects what the supervisee notices and encodes. This is not to say that anxiety is to be warded off. Rather, the more anxiety supervisees are able to allow themselves – within limits – the more they are able to learn.

Second, anxiety affects the supervisee's performance. Performance is concerned with what the supervisee learned and can put to practice. It has been observed that supervisee performance is negatively related to their anxiety levels. One of psychology's most famous hypotheses is that:

> Anxiety is an arousal state that, in moderate amounts, motivates the individual and facilitates his or her task performance. Yet an individual's performance suffers when he or she experiences either too little or too much anxiety: too little, and one lacks sufficient motivation to perform; too much, one is debilitated. (Bernard & Goodyear, 2014, p. 93)

One important source of supervisee anxiety is the fact that their work is observed and evaluated continuously.

Third, anxiety affects the quality of engagement with the supervisor. The state of anxiety can affect how the supervisee relates to the supervisor and to how much they withhold from him. Ronnestad and Skovholt (1993) note that "the anxious student may tend to discuss in supervision only clients who show good progress, choose themes in which he is functioning well, or choose a mode of presenting data that allows full control over what the supervisor learns" (p. 398). In social psychology this is referred to as *impression management*. There are several reasons why a supervisee would like to manage the impression that the supervisor has of him. One is to present himself as having the characteristics and skills that the supervisor thinks are necessary to be an effective therapist.

The supervisor can help the supervisee manage anxiety in several ways. First, the supervisor can normalize anxiety and give the supervisee permission to take risks and make mistakes. One can add that a key component is how to repair mistakes and then move on. Second, the supervisor can provide an optimal balance between support and challenge: "Too much support and too little challenge robs the supervisee of initiative and the opportunity to try new behaviors; too little support and too much challenge and the supervisee may become overwhelmed and incapacitated" (Bernard & Goodyear, 2014, p. 95).

Supervisee's need to feel and appear competent

A supervisee's motivation to feel competent varies according to their level of development as a supervisee (e.g., novice, intermediate, advanced). Beginning-practicum students, when compared to intern-level supervisees, rated as being more important the belief that they have sufficient skills as counsellor or psychotherapist to be competent in working with their clients (Rabinowitz, Heppner, & Roehlke, 1986).

Another competency-related phenomenon is the supervisee feeling that he is an imposter and fearing being found out. They feel that it will only be a matter of time before they are found out to be the imposters that they believe themselves to be. This occurs particularly when the supervisee's actual competency exceeds that of their felt competency.

Supervisee transference

In broad terms, the supervisee might develop negative or positive transference-based responses towards their supervisors. When these responses are extreme, they reflect vestiges of unresolved child-parent relationships. As an example of a negative transference-based response, the supervisee might perceive the supervisor to be more punitive and critical than is actually the case. This response might be a function of the supervisee projecting his own punitively self-critical evaluations of himself onto the supervisor (Cashdan, 1988).

In terms of a positive transference-based response, the supervisee might idealize his supervisor which might fill the need to have a "relationship with someone who seems more competent and therefore capable of guiding their learning and development, someone to serve as a model" (Bernard & Goodyear, 2014, p. 98). Another form of transference-based response is sexual attraction that can have various origins including having shared interests. Another source of transference could originate from parallel process, that is, the supervisee relates to the supervisor as the client relates to the supervisee (Frawley-O'Dea & Sarnat, 2001).

What is the role of the supervisor in helping the supervisee manage his transference? Regarding positive transference-based response (e.g., idealization), the supervisor "should steer a careful course … respect the supervisee's need to idealize the supervisor … [but not allow] … the idealization of the supervisor to cheat the supervisee of the chance to develop his own sense of competence" (Bernard & Goodyear, 2014, p. 98). Negative transference-based responses are more difficult and the manner to deal with them depends on their nature. In any case the transferences need to be addressed and resolved. More will be said about this in chapter seven.

Supervisor factors

Before presenting the supervisor factors that affect their level of engagement, it should be mentioned that it is important for the supervisor to trust that supervisees are being honest and forthright about the material that they present about their clients. As well, the supervisor has his own anxieties to deal with. The source of these anxieties might come from evaluations and from the sense of responsibility towards both the supervisee and to the public that they will serve if successful in training. Another source of anxiety may come from a client being in crisis and the supervisor wondering about the supervisee's ability to handle it. The supervisor factors that affect the supervisory relationship include attachment style, power, and countertransference.

Supervisor attachment style

In a study by White and Queener (2003), supervisor's attachment style, as rated by both supervisor and supervisee, was found to predict the strength of the supervisory alliance. The authors concluded that "this study suggests that supervisors' ability to make positive-affiliative attachment with others play(s) an important role in understanding the supervisory relationship" (p. 214). In another study, Foster, Heinen, Lictenberg, and Gomez (2006) observed that supervisors with a preoccupied attachment style tended to give their supervisees lower professional ratings than their colleagues with other attachment styles. That is, the supervisors with a preoccupied attachment style seemed to be impaired in their ability to accurately evaluate supervisees.

Interpersonal power

The fact that the supervisory relationship is hierarchical in nature implies that the supervisor has influence on the supervisee's professional behaviours. The influence that a supervisor has in the supervisory relationship is dependent upon the supervisee's perception of the supervisor's expertise, attractiveness (e.g., perceived similarities in goals and values), and trustworthiness. Power as understood in supervision does not involve dominance and control of one person over the other. Since power is based on communication, the supervisor and supervisee can influence each other, although the supervisor has the greater role-based power and therefore greater influence. It is incumbent upon the supervisor to be aware of his power in the supervisory relationship and to use it effectively and without abusing it to enhance the supervisee's learning and to protect the client. Misuse of power on the part of the supervisor can invite supervisee resistance and positive or negative transference responses (Bernard & Goodyear, 2014, pp. 99-104).

Supervisor countertransference

Bernard and Goodyear (2014, pp. 104-106) summarize six sources of supervisor countertransference that were inferred by Ladany, Constantine,

Miller, Erickson, and Muse-Burke (2000) and Lower (1972). The sources are:

1. Countertransference triggered by the interpersonal style of the supervisee (e.g., defensiveness, assertiveness, shyness, warmth, and being engaging for erotic countertransference).
2. Countertransference stemming from some aspect of the supervisor's own unresolved personal issues (e.g., family issues, concerns about competency, and his own interpersonal style such as strong need to be liked or having unduly high self-expectations).
3. Countertransference stemming from general personality characteristics (e.g., characterological defences).
4. Countertransference stemming from inner conflicts reactivated by the supervisory situation (e.g., need to play favourites with supervisees, encouraging supervisee to act out his own conflicts with other colleagues, and competing with other supervisors).
5. Reaction to the individual supervisee (e.g., supervisee seems brighter and better financially off than supervisor and sexual or romantic attraction).
6. Countertransference to the supervisee's transference. It is incumbent upon the supervisor to learn to manage his countertransference. Methods to deal with countertransference are presented in more detail in chapter seven.

Summary

This chapter presents the definition of clinical supervision, indicated how it differs from administrative supervision, and cautioned against a supervisor assuming both roles. The goals of supervision comprise protecting the welfare of the client, guiding the professional development of the supervisee, and facilitating the supervisee's self-awareness, self-development, and understanding. The supervisor's functions that help to implement the goals of supervision include the normative, restorative, and formative functions. In addition to these more technical and professional

functions, it is important for the supervisor to focus on the supervisor and supervisee relationship and to develop an attitude that enlivens the supervisory process and outcome. Of importance in this regard is for the supervisor to assign the highest value to supervision as a crucial educational experience, to commit fully and actively to supervision and to the continuing development of the supervisee, and to supremely privilege and esteem the supervisor and supervisee relationship and assign it a preeminent value as a crucial mechanism of the supervision engagement. It is important for the supervisor to be keenly aware of and anticipate the supervisee factors and supervisor factors that might negatively affect the engagement of the supervisor relationship and to address them when they emerge. Although supervision is evaluative and hierarchical, the supervisor should make efforts to create an environment where the supervisee feels safe and secure. Supervision needs to strive to balance the supervisor's task of being "gatekeeper" with him developing a relationship with the supervisee which is more akin to mentorship. The following chapter presents models of supervision that a supervisor can adopt to guide his task as supervisor.

CHAPTER 2
Models of Clinical Supervision

Clinical supervision began as the practice of observing, assisting, and receiving feedback. Supervision followed the framework and techniques of the specific psychotherapy theory being practiced by the supervisor and supervisee. With the increased need for specific supervisory interventions, models of supervision within each theory developed to address this need (Smith, 2009).

There is a consensus among scholars in the supervision field and among supervisors that a theory or model of supervision is necessary for effective supervision practice (Haynes, Corey, & Moulton, 2003). Clinical supervision models are important as they are the "systematic manner in which supervision is applied" (Leddick, 1994, p. 1), and they help the supervisor to conceptualize and make sense of experiences and dynamics of the client (Aasheim, 2012, p. 36). Supervision models provide "a theoretical description of what supervision is and how the supervisee's learning and development occur" (Haynes et al., 2003, p. 109); influence the supervisor's behaviours, roles, approaches, and attitudes (Goodyear, Abadie, & Efros, 1984); and shape the form and function of a supervision experience. Hart (1982) noted that "one can imitate an outstanding supervisor, but without theory or a conceptual model one does not really understand the process of supervision" (p. 27).

What makes for an adequate supervision theory or model? Speaking generally, Bernard and Goodyear (1994) point out six criteria for a good theory. These are: (1) preciseness and clarity (i.e., the theory should be understandable and internally consistent); (2) parsimony or simplicity (i.e., the theory should employ only the minimum number of assumptions and

interrelationships that are necessary to explain the targeted domain); (3) comprehensiveness (i.e., the theory should make use of known data of a domain); (4) operationality (i.e., the theory's hypotheses and assumptions should be clearly expressed in measurable terms); (5) practicality; and (6) falsifiability (i.e., the theory should be expressed in such a manner that its propositions can be disproved).

Haynes et al. (2003) do not speak about a theory of supervision, but rather about models of supervision. According to these authors, supervisory models are considered to be adequate if they meet the following conditions: (1) describe how learning and development occur; (2) explain the role of individual and cultural differences in the supervision process; (3) contain elements that structure the goals of supervision; (4) determine the role of the supervisor; (5) indicate intervention strategies; and (6) describe the role of evaluation in supervision.

This section presents brief summaries of the main supervision models with their salient supervisory elements. These models are grouped according to psychotherapy-based supervision models, developmental models of supervision, social role models, critical events model, systems approach, feminist approach to supervision, and process models.

Psychotherapy-based models of supervision

Psychotherapy-based models are keyed to particular therapeutic approaches and feel like an extension of the psychotherapy itself. There is an uninterrupted flow of terminology, focus, and technique from the therapy session to the supervision session (Smith, 2009). Falender and Shafranske (2009) state that "theoretical orientation informs the observation and selection of clinical data for discussion in supervision as well as the meanings and relevance of those data" (p. 9). Those who adopt a particular therapeutic approach believe that the best supervision is the "analysis of practice for true adherence to the therapy" (Leddick, 1994, p. 2). The advantage of psychotherapy-based supervision is that if both the supervisor

and supervisee share the same orientation, modelling is maximized and theory is more integrated into training.

In the 2010 edition of the journal *Psychotherapy: Theory, Research, Practice and Training*, the editors, Farber and Kaslow (2010), requested authors from various theoretical orientations to submit articles on the foundational competencies and functional competencies required of its supervisors. The focus of these articles was competency-based practice in professional psychology. In commenting on the presentations in this special edition, Falender and Shafranske (2010) distinguished between theoretical models of supervision and psychotherapy-based approaches to supervision. The authors commented that for supervision to go forward, it "requires going back to the psychotherapy-based supervision, affirming its unique role in professional training, and infusing its practice with competency-based principles" (p. 48). This comment is in keeping with competency movement which includes a "shift from a knowledge base to a competence base" (p. 45). Several of the psychotherapy-based supervision models together with their foundational competencies and functional competencies are briefly described.

Psychodynamic approach to supervision

Psychodynamic-oriented supervision models draw on the clinical data inherent to that approach such as affective reactions, defence mechanisms, transference, countertransference, and conflicts. Frawley-O'Dea and Sarnat (2001) classify psychodynamic supervision models into three groups: patient-centred; supervisee-centred; and supervisory-matrix centred.

Patient-centred: This focuses the supervision session on the patient's presentation and behaviours. The role of the supervisor is didactic with the goal to help the supervisee understand and treat the problems. The supervisor is seen as the uninvolved expert who has the knowledge and skills to assist the supervisee. Because the supervision is on the patient and not on the supervisee or the supervisory process, little conflict occurs

between supervisor and supervisee on the condition that both interpret the material in the same way (Frawley-O'Dea & Sarnat, 2001).

Supervisee-centred: In this approach, there is a shift from focusing on the patient to focusing on the content and process (e.g., anxieties, resistance, learning problems) of the supervisee's experience as a counsellor. This approach to supervision can stimulate growth for the supervisee by gaining an understanding of her own psychological processes (Smith, 2009). This approach was adapted to fit the emerging psychodynamic theories such as Ego Psychology, Object Relations, and Self Psychology (Frawley-O'Dea & Sarnat, 2001). The supervisor's role in this approach remains that of the uninvolved expert and supervision; using this approach is more experiential than didactic (Falender & Shafranske, 2004).

Supervisory-matrix centred: The focus of this approach to supervision is the material from the client and the supervisee and the relationship between supervisor and supervisee. The supervisor's role is no longer one of the uninvolved expert. Supervision within this approach is relational and the supervisor's role is to "participate in, reflect upon, and process enactments, and to interpret relational themes that arise within the therapeutic dyads" (Frawley-O'Dea & Sarnat, 2001, p. 41). This includes an examination of parallel process which is defined as "the supervisee's interaction with the supervisor that parallels the client's behavior with the supervisee as the therapist" (Haynes et al., 2003).

In an article, Sarnat (2010) elaborated on the key foundational and functional competencies for psychodynamic therapy. Two foundational competencies are relationship and self-reflection and two salient functional competencies are assessment-diagnosis-case conceptualization and intervention.

Foundational competencies: Relationship competencies include "creating an alliance, titrating client anxiety, and facilitating client attachment" (Sarnat, 2010, p. 23). Psychodynamic psychotherapy views the

relationship as the crucible of psychotherapeutic change and therefore must go beyond the competencies mentioned above. The therapist becomes immersed in the relationship and then begins to transform the patterns of defence, anxiety, and enactments that emerge in their relationship. The therapist develops the capacity to maintain emotional contact with the client. Self-reflection competency entails "a highly developed capacity to bear, observe, think about, and make psychotherapeutic use of one's own emotional, bodily, and fantasy experiences when in interaction with a client" (p. 23). The supervisee needs to learn to tolerate difficult affects in the psychotherapeutic and supervisory relationship including the feelings of anger, guilt, need, and dependence both in herself and in the client.

Functional competencies: The two salient functional competencies in a psychodynamic approach are assessment-diagnosis-case conceptualization and intervention. Assessment considers the whole person and includes the following symptoms: "conscious and unconscious conflicts, internalized relational patterns, interpersonal patterns and defenses" (Sarnat, 2010, p. 24). Conceptualization refers to formulating an understanding of the client that is based on the "client's actions, affects, avoidances, self-reports and history" and on the "affective, fantasy, and somatic responses that are evoked within the psychotherapist" (p. 24). The second functional competency is intervention which from a psychodynamic perspective is often understood to mean interpretation. From a relational perspective, "the distinction between interpretation and relationship participation is understood to be an arbitrary one, and insight and change are understood to result from both" (p. 24). How one conducts a psychotherapeutic relationship always has an interpretative implication and all interpretation as understood to be actions taken in the relationship. Ablon and Jones (2005) describe this relationship this way:

Insight and relationship have complementary roles, since psychological knowledge of the self can develop only in the context of a relationship within which the psychotherapist endeavors to understand the mind of the patient through the medium of their interaction (pp. 564-565).

Cognitive-behavioural supervision

The cognitive-behavioural approach to supervision is characterized by its assumptions and goals. Some of the assumptions underlying a cognitive-behavioural orientation to supervision include: (1) the delivery of service can be discretely identified, observed, and causally related to usefulness and effectiveness with an identified client; (2) the effectiveness of skills can be evaluated empirically; (3) behavioural interventions can increase or decrease and assist in developing new behaviours; and (4) these approaches can be replicated in multiple settings. The goals of a cognitive-behavioural-oriented supervisor are: (1) to establish a set of conditions that will help the supervisee adopt a particular philosophy of behaviour and behaviour change, (2) to assist the supervisee to apply an analytic method to functionally analyze and understand client problems, (3) to learn to apply a distinct set of basic behavioural principles to client problems, and (4) to provide a theoretically driven rationale explaining how treatment will occur using these principles (Kaufman & Schwartz, 2003, p. 150).

An important task for a cognitive-behavioural supervisor is to teach the techniques of theoretical orientation. To perform this task, the cognitive-behavioural supervisor makes use of observable cognitions and behaviours, particularly in relation to the supervisee's professional identity and her reactions to the client (Haynes et al., 2003). The techniques that a cognitive-behavioural supervisor uses in supervision include setting an agenda for the supervision sessions, making links from previous sessions, assigning homework to the supervisee, and providing summaries of the sessions (Liese & Beck, 1997).

Newman (2010) offers a model of supervision based on Rodolfa, Eisman, Nelson, Rehm, and Ritchie's (2005) cube model which examines expertise in conducting psychotherapy across three dimensions, namely foundational competencies, functional competencies, and a developmental dimension (i.e., stage of professional development of therapist). In the paper, Newman summarizes the foundational and functional competencies of the therapist

and indicates how a supervisor facilitates the development of these competencies.

Foundational competencies: The competencies required to conduct cognitive-behavioural therapy include: respecting and understanding the scientific underpinnings of the treatment; skill in managing the therapeutic relationship; cultural competency; and intercollegial, interdisciplinary collaboration and consultation (Newman, 2010, pp. 13-14). Foundational competencies for the supervisor include: having awareness of diversity and cultural differences and openly speaking about them; having awareness of the power that they wield in the lives of their trainees; and being role models for ethical decision-making, ongoing self-education, maintaining boundaries, and being adept at interdisciplinary collaboration and consultation (p. 16).

Functional competencies: An overarching competency of an effective and competent CBT therapist is learning how to think like an empiricist. Central to being an empirically sophisticated empiricist is to collect data via reliable means, generate and test hypotheses, and devise sensible interventions based on the hypotheses. An additional competency is to teach clients how to think more empirically in the form of differentiating between subjective experience and objective evidence, self-monitor relevant aspects of their own functioning, reduce the tendency to draw causal inferences from correlational situations, and devise hypotheses that can be tested using behavioural experiments. Some of the core techniques that CBT therapists need to practice and master and teach their clients are: self-monitoring, asking guided discovery questions to evaluate automatic thoughts, practice new ways of functioning by using role-plays and assigning homework, and relaxation and controlled breathing exercises (Newman, 2010, pp. 14-15).

The CBT supervisor teaches her trainees how to conceptualize in CBT terms, directs the trainees toward resources (e.g., video tapes, literature) that introduce them to a full range of technical skills, and provides them with opportunities to practice such skills (e.g., role-playing in supervision).

Supervisors may periodically listen to their supervisee's recorded sessions with the supervisee to provide highly specific feedback. The supervisee might also use the Cognitive Therapy Scale (Young & Beck, 1980) to give their supervisees quantitative and qualitative ratings on essential elements of cognitive therapy (Newman, 2010, pp. 16-17).

Person-centred supervision

Similar to Roger's person-centred therapy that believes that clients have the capacity to effectively resolve life problems without interpretation and direction from the counsellor, the person-centred supervisor believes that a supervisee has the resources to develop as a counsellor. The supervisor is seen not as the expert, but as a collaborator with the supervisee. The role of the supervisor is to provide an environment in which the supervisee can be open to her experience and engage fully with the client (Lambers, 2000). In person-centred therapy, "the attitudes and personal characteristics of the therapist and the quality of the client-therapist relationship are the prime determinants of the outcomes of therapy" (Haynes et al., 2003, p. 118). Person-centred supervision adopts this tenet and relies heavily on the relationship of the supervisee-supervisor to facilitate reflective learning and growth in supervision.

Farber (2010) elaborates on the foundational and functional competencies of humanistic-existential psychotherapy and how supervision can help the therapist to develop these competencies. The essential foundational competencies include reflective practice and relationships and the significant functional competencies include the competencies of assessment and intervention.

Foundational competencies: The two foundational competencies include reflective practice and relationships. Reflective practice refers to "competency in professional self-reflection, including self-assessment of professional strengths and skill levels along with areas in need of further professional development" (Farber, 2010, p. 31). Self-reflection equips the therapist to set aside her biases and provides an anchor so that the therapist

may become immersed in the client's experiential world and at the same time retain separateness from the client. The second foundational competency is relationship which "involves effective and adaptive interpersonal capacities including respectfulness, caring, communication skills, and skills in managing feelings in interpersonal contexts" (p. 31). Relationship competency implies "engaging with people in a deeply valuing, and respectful way" (Cooper, 2007, p. 11).

Functional competencies: The significant functional competencies for the humanistic-existential therapist include the competencies of assessment and intervention. Assessment competency requires skill in evaluation, diagnosis, and conceptualization of problems and concerns (Farber, 2010, p. 31). In providing an assessment, the therapist takes into account the client's life circumstances and attends to the multiple modes through which the client communicates experiences (e.g., actions, emotions). In brief, assessment competency refers to the therapist's skill to develop a phenomenological description of the client's experience as a whole person. Intervention competency refers to the "effective use of psychological methods to diminish problems and promote personal growth. The therapist accomplishes this goal by facilitating experiential awareness and the relationship to attune to the client's needs" (p. 32).

The humanistic-existential-oriented supervisor pays attention to three aspects of the supervisory relationship, namely expanding the supervisee's knowledge of theory and technique, exploring the person of the supervisee, and cultivating skills in the use of self as a change agent. These skills have the goal to facilitate experiential awareness and learn how to use the relationship to promote change. Regarding the development of knowledge, the supervisor guides the supervisee in developing assessment and intervention competencies using humanistic-existential concepts. The focus on the person of the supervisee entails the development of reflective practice competency by cultivating capacities to use self-reflection and self-knowledge in the service of the client. Lastly, the supervisor helps the supervisee to cultivate the use of self as a change agent which includes the

capacities for genuineness, basic acceptance, and presence in the psychotherapy encounter (Farber, 2010, pp. 32-33).

Parallel process and isomorphism supervision models

The supervisory relationship may be impacted by individuals who are not present during supervision, such as the client, and this presence deeply affects the quality of the supervision taking place. The nature of these interactions has been described in terms of parallel processing and isomorphism. The concept of parallel processing has its conceptual roots in psychodynamic theory (Haley, 1976) whereas isomorphism has its roots in systems theory (White & Russell, 1997).

The concept of parallel process, first used by Searles (1955), is bi-directional in nature with the supervisee playing out with the client what the supervisee experienced with the supervisor. That is, parallel process refers to the supervisor and supervisee's interactions that often mirror the supervisee's interactions with clients (Ekstein & Wallerstein, 1972).

Parallel process supervision models have their origin in the psychoanalytic concepts of transference and countertransference. Transference is the supervisee's re-creation, within the supervision relationship, of the problems and emotions of the therapeutic relationship. Countertransference is the response of the supervisor to the supervisee which is the same as that of the supervisee's response to the client. Thus, the supervisory interaction replays or parallels the counselling interaction (Sumerel, 1994).

In supervision, parallel process refers to the relational and structural similarities between therapy and supervision. Friedlander, Siegel, and Brenock (1989) describe parallel process as a phenomenon in which "supervisees unconsciously present themselves to their supervisors as their clients have presented to them. The process reverses when the supervisee adopts attitudes and behaviors of the supervisor in relating to the client" (p. 149). Thus, parallel processing is the re-enactment of processes in one

dyadic relationship (e.g., supervisor-supervisee) in another relationship (e.g., supervisee-client) or vice versa.

Parallel processing can be seen from two different perspectives. On the one hand, the supervisor in a supervision session might be hesitant to ask questions about a topic in the same way that a supervisee is hesitant to ask the client questions about a topic. Aasheim (2012) provides the following example:

A supervisee may recognize that she is hesitant to ask the supervisee questions that seem very personal in nature. She does not understand why she feels this hesitance and is disturbed by it. Similarly, the supervisor notices that, in supervision, he feels hesitant to ask the supervisee particular things about the client. In that this hesitance is unusual, he notices it and wonders about the meaning of this unusual occurrence. (p. 172).

As another example of parallel processing, in a therapy session the client becomes angry when she is confronted. In a supervision session one week later, the supervisee presents as angry when the supervisor suggests some potential course of action (Koltz, Odegard, Feit, Provost, & Smith, 2012, p. 234).

On the other hand, the supervisee might bring to her counselling of a client the way the supervisor treated her. For example, a supervisor may impose her values on the supervisee who in turn imposes these same values on the client. Alternatively, a supervisor who is impatient with the supervisee may in turn be impatient with the client. The parallel process occurs when the supervisee “exhibits the impatience she felt with the supervisor in the therapeutic relationship with the client” (Sumerel, 1994, p. 1).

It is of benefit to the supervisee to pay attention to the parallel process, when it emerges, because the supervisee will become aware of how she is involved in the therapeutic relationship and learn how to use herself in the

counsellor/client relationship. The timing for the discussion of parallel process issues, however, is important (Aasheim, 2012, pp. 172-173).

Stoltenberg and Delworth (1987) think that beginning counsellors do not possess the self-awareness required to deal with transference and countertransference issues. Beginning counsellors, they hold, are not aware of how they impact the therapeutic relationship and are concerned with learning techniques and skills. Other authors, such as McNeill and Worthen (1989), think that transference and countertransference issues can be discussed with entry-level counsellors, but the interventions should be concrete and simple and the focus should be primarily on self-awareness issues. Experienced and advanced counsellors, on the other hand, have acquired a capacity to understand and integrate self-knowledge gained through transference and countertransference reactions in their therapist/client relationships. Being less defensive with regard to their issues becoming a focus in supervision, advanced counsellors have developed therapeutic skills and techniques to address these issues and in fact are more inclined to discuss how transferential and countertransferential issues impact their therapeutic relationship.

Morrissey and Tribe (2001) and Berger and Buckholz (1993) demonstrate how parallel processing applies within the context of systems theory, such as in couple therapy. The application of parallel processing to systems theory is referred to as isomorphism. Unlike in parallel processing where the focus is on the intrapsychic or internal, in isomorphism the focus is on the inter-relational that presents itself as “replicating structural patterns between counselling and supervision” (Koltz et al., 2012, p. 234). When replicating patterns between counselling and supervision occurs, the supervisee and supervisor duplicate the role of the client and counsellor. Koltz et al. (2012) state that an isomorphism, essentially, is a “repetitive relational pattern that occurs in supervision; his focus on a recurrent pattern is what separates a parallel process from an isomorphism” (p. 234).

Using the case of the angry client mentioned above, an isomorphism would be said to occur during supervision under the conditions where the counsellor, during the therapy session, would ignore the client's anger and then later, in the supervision session, the supervisor would ignore the supervisee's anger. The inter-relational pattern occurring in counselling now occurs in supervision – this is an isomorphism (White & Russell, 1997).

When parallel processing and isomorphism are considered more carefully, it becomes apparent that parallel processing includes both a motivational component and a behavioural component whereas isomorphism comprises a behavioural component. To illustrate the differences, reference is made to the angry patient presented above. In the case of parallel processing, the therapist's behaviour can be said to be motivated to please the client and to be seen as a caring therapist. In the case of isomorphism, although the focus is on the inter-relational pattern, there still remains a motive that drives the relational pattern. In brief, parallel processing focuses both on the motive and behaviour whereas isomorphism focuses solely on the behaviour.

Developmental models of supervision

The developmental models of supervision are likely the most widely accepted and embraced models of supervision (Milne, 2009). These models have two underlying assumptions, namely growth is ongoing and learning is a lifelong process. As the supervisees gain experience, the behaviour of the supervisor changes, thus creating a dynamic change in the supervision experience (Kaufman & Schwartz, 2003, p. 151).

These models assume that supervisees continuously grow in growth spurts and patterns and pass through a number of predictable, universal stages in their growth. Each stage is characterized by particular tasks, needs, and conflicts that the supervisee must work through to continue her growth. For example, supervisees at the novice stage of the developmental spectrum would be expected to have limited knowledge and skills and lack confidence as counsellors. Supervisees at the middle stage might have more

skills and confidence and might experience conflicting feelings about perceived independence/dependence on the supervisor. A supervisee at the expert stage end of the developmental spectrum is likely to use effective problem-solving skills and reflect on the counselling and supervisory process (Haynes et al., 2003).

For the supervisor using a development approach to supervision, the key is to accurately identify the supervisee's current stage of development and to provide feedback and support appropriate to the stage of development while helping the supervisee to progress to the next stage of development (Stoltenberg & Delworth, 1987). To achieve this goal, the supervisor uses an interactive process often referred to as scaffolding (Zimmerman & Schunk, 2003). This method encourages the supervisee to use prior knowledge and skills to produce new learning and move to the next stage. As the supervisee approaches mastery at a given level, the supervisor gradually raises the scaffold to incorporate knowledge and skills from the next advanced stage (Smith, 2009). The task of the supervisor is to recognize the supervisee's stage-based needs and adopt methods, style, or focus of supervision that facilitates optimal development (Morgan & Sprenkle, 2007). The goal of supervision is to maximize and identify new areas of growth in a lifelong learning process. In being helped to identify their growth areas and strengths, supervisees are enabled to be responsible for their lifelong growth as therapists.

Two of the developmental models are the Integrated Developmental Model (Stoltenberg, McNeil, & Delworth, 1998) and Lifespan Developmental Model (Ronnestad & Skovholt, 2003). These two models are briefly presented and described.

Integrated Developmental Model (IDM)

Stoltenberg, McNeil, and Delworth (1998) and Stolenberg and McNeil (2010) proposed a developmental model with three levels of supervisees: Level 1 (Beginning); Level 2 (Intermediate); and Level 3 (Advanced). Each level has three trends, that is, overriding structures that trace progress of

trainees: (a) self-and-other awareness, (b) motivation, and (c) autonomy. The model is applied to eight growth areas for each level of supervisee (e.g., skills competence, client conceptualization, interventions, and interpersonal assessment). To the three levels, the authors also added a Level 3i (Integrated) which is characterized by integration across multiple domains (Bernard & Goodyear, 2014, p. 36) (Table 2.1). The IDM has a cognitive base but more apparent is the development of expertise.

Level 1 supervisees are generally entry-level students with high motivation and a fearfulness of evaluation. They are found to be relatively dependent on the supervisor to diagnose clients and plan treatment procedures. Level 2 supervisees experience fluctuating confidence and motivation and often link their own mood to success with clients. Level 3 function independently, feel responsible for their decisions, and seek consultation when appropriate. They are essentially secure, stable in motivation, express accurate empathy tempered by objectivity, and use therapeutic self in interventions (Leddick, 1994; Smith, 2009). Hawkins and Shohet (1989) suggest a Level IV (p. 51) which Stoltenberg and Delworth refer to as “Level III Integrated” (Level 3i). By this time the practitioner has reached master level “characterized by personal autonomy, insightful awareness, personal security, stable motivation and an awareness of the need to confront her own person and professional problems” (Stoltenberg & Delworth, 1987, p. 20). That is, the supervisees have become supervisors themselves which can consolidate and deepen their learning (Hawkins & Shohet, 1989, p. 52).

Table 2.1

Integrated Developmental Model: Levels of supervisees, domains of professional functioning, and overriding structures

Levels of Supervisee/ Growth areas of Functioning	Level 1: Novice	Level 2: Intermediate	Level 3: Advanced
Intervention skills			
Assessment techniques			
Interpersonal assessment			
Client conceptualization			
Individual differences			
Theoretical orientation			
Treatment plans/goals			
Professional ethics			
Overriding structures that trace progress in trainees:			
Self-and-other awareness	- High self-focus; limited self-awareness	- Better able to empathize with client	- Self-aware, remains focused on client; uses self-awareness therapeutically
Motivation and anxiety	- High; wants to learn skills	- Fluctuates twix confident and less confident	- Consistent; has doubts that do not immobilize
Autonomy	- Dependent on supervisor; needs structure	- Conflicted twix autonomy and independence	- Solid belief in one's judgment

The three trends (i.e., structures that trace the progress) that go across the levels are self-other awareness, motivation, and autonomy. The self-other awareness refers to the supervisee's self-preoccupation and awareness of their client's experiences in terms of cognitive and affective elements. As the supervisee moves from the beginning to the advanced level, there is a shift from attention to their own internal processes to authentic and empathic connection with client; that is, she develops a greater capacity and understanding of the client's viewpoint. As for motivation, this may lessen when the supervisee feels confused and ambivalent and may increase when she feels more confident. As for autonomy, this will fluctuate over time with supervisees' demonstrating independence, dependence, and counterdependence (Assheim, 2012, p. 42).

The eight domains of professional functioning in which the supervisees will progressively gain competency are: (1) intervention skills competency; (2) assessment techniques; (3) interpersonal assessment; (4) client conceptualization; (5) individual differences; (6) theoretical orientation; (7) treatment plans and goals; and (8) professional ethics (Assheim, 2012, p. 45).

In terms of supervision, the supervisor must use skills and approaches that correspond to the level of the supervisee. For example, when supervising a Level 1 supervisee, the supervisor needs to balance the supervisee's high anxiety and dependence by being supportive and descriptive. When supervising a Level 3 supervisee, the supervisor emphasizes the supervisee's autonomy and collegially challenges the former (Smith, 2009).

The IDM does have some weaknesses. First, it focuses predominantly on the development of graduate students with little emphasis on post-graduate professionals. Second, it presents limited supervision methods that are applicable at each level of supervision (Haynes, Corey, & Moulton, 2003; Smith, 2009). An alternative developmental model is proposed by

Ronnestad and Skovholt (2003) who provide a framework to describe development across the lifespan of the counsellor's career.

Lifespan Developmental Model

Based on the data from a qualitative study of 100 counsellors/therapists, Ronnestad and Skovholt (2003) developed a six-phase model of supervisee development. The first phases, which correspond to the phases of the IDM, are: The Lay Helper; The Beginning Student Phase; and The Advanced Student Phase. The remaining three phases, which are self-explanatory, are: The Novice Professional Phase; The Experienced Professional Phase; and The Senior Professional Phase.

In addition to the six-phase model, Ronnestad and Skovholt's (2003) analysis identified 14 themes in counsellor development. Smith (2009, p. 6) summarized these themes as follows:

1. Professional development involves an increasing higher-order integration of the professional self and the personal self.
2. The focus of functioning shifts dramatically over time from internal to external to internal.
3. Continuous reflection is a prerequisite for optimal learning and professional development at all levels of experience.
4. An intense commitment to learning propels the developmental process.
5. The cognitive map changes: beginning practitioners rely on external expertise, and seasoned practitioners rely on internal expertise.
6. Professional development is a long, slow, continuous process that can also be erratic.
7. Professional development is a lifelong process.
8. Many beginning practitioners experience much anxiety in their professional work. Over time, anxiety is mastered by most.
9. Clients serve as a major source of influence as well as being primary teachers.

10. Personal life influences professional functioning and development throughout the professional lifespan.
11. Interpersonal sources of influence propel professional development more than "impersonal" sources of influence.
12. New members of the field view professional elders and graduate training with strong affective reactions.
13. Extensive experience with suffering contributes to heightened recognition, acceptance, and appreciation of human variability.
14. For the practitioner, there is a realignment from self as hero to client as hero.

In brief, Ronnestad and Skovholt (2003) conclude that therapist/counsellor development is a complex process that requires continuous reflection.

Reflective Developmental Model

Dewey (1933) is credited as making the first formal statement about how to use reflection to improve practice. Reflection is defined as a "process that begins with a professional practice situation that is somehow upsetting, surprising, or confusing" (Bernard & Goodyear, 2014, p. 39). This situation, referred to as a *trigger event*, sets in motion a critical review of the situation that leads to a new and deeper understanding of that situation. Reflection, as understood in professional practice, goes beyond the original understanding to shed light on what might be. In this way, reflection is developmental. The triggering event can be related to the supervisee's skills, knowledge, and/or emotional reactions to clients. For example, a supervisee might wonder why a particular intervention that she used did not work. Reflecting on this situation might shed new light on why it was not effective. Various techniques have been developed to promote self-reflection and are

presented in the chapter under Interventions. It is assumed that the supervisee will implement the new understanding when similar situations arise.

Social role models of supervision

Social role models of supervision, also referred to as integrative models of supervision (Smith, 2009), are designed to be used by therapists and supervisors who integrate several theories into a consistent practice. The focus of these models is primarily the role that the supervisor plays in supervision. These models, which are not tied to a particular counselling theory and tend to be more descriptive in nature, attempt to provide a way to organize the various tasks done by supervisors. Social role models include: the Discrimination Model (Bernard, 1997); Systems Approach to Supervision (Holloway, 1995); Williams' (1995) Social Role Model; the Critical Events Model of supervision (Ladany, Friedlander, & Nelson, 2005); feminist approach to supervision (Wheeler, Miller, & Chaney, 1986); and systemic supervision. The social role models are considered to be atheoretical and offer a way to describe what may take place in supervision and in the factors that impact the supervision process (Morgan & Sprenkle, 2007, p. 4).

Discrimination Model

The most well-known social role model is Bernard and Goodyear's (1994, 2014) Discrimination Model, a training model that purports to be atheoretical. The model presents supervisors with a three by three matrix (three focus areas and three supervisor roles) from which to choose. The three focus areas are intervention skills, conceptualization skills, and personalization skills (Bernard, 1997). The supervisor roles include teacher, counsellor, and consultant.

The supervisor selects a topic from three different domains referred to as focus areas. One of the focus areas is *intervention skills* which refers to a supervisee's observable actions during a session, what skills are

demonstrated, and how effectively they are used. A second focus area is *conceptualization skills* which refers to how a supervisee understands what is happening in a session, identifies patterns and major themes, understands interpersonal dynamics, chooses interventions, and organizes the many aspects of the counselling experience. A third focus is *personalization skills* which is described as the manner in which a supervisee's personality and personal style relate to the therapeutic process and how the supervisee attempts to keep counselling uncontaminated by personal issues and countertransference (Bernard & Goodyear, 2014, p. 52).

Once the supervisor has made a judgment about the supervisee's abilities within each of the focus areas, she then decides which role to take to accomplish the supervision goals. The role that the supervisor takes will affect how the supervisee is approached by the supervisor. These roles, however, are not assumed in their literal sense but "draw from the skill base related to that role and incorporates those types of skills into the supervision activity" (Aasheim, 2012, p. 50).

According to the social role model, a supervisor might assume one of three different roles, namely teacher, counsellor, and consultant. The supervisor assumes the "teacher" role when she believes that the supervisee needs structure that might include teaching, instructing, giving feedback, and modelling. The supervisor assumes the "counselling" role when she wishes to enhance supervisee reflectivity, especially about her internal reality, and help the supervisee to identify unresolved issues interfering with therapeutic relationship. In assuming the role of a "consultant," the supervisor acts as a colleague who wishes for the supervisee to trust her own insights and feelings about her work, or when the supervisor thinks that it is important to challenge the supervisee to think or act on her own. Each of the three roles is designed for a specific task within supervision (Bernard & Goodyear, 2014, p. 52). Table 2.2 presents the possible combinations of focus area by supervisor roles.

At any given moment during the supervision, the supervisor will select one focus area and evaluate the supervisee's skill in that area. The supervisor then selects the role best suited for that level of ability. For example, a teaching role would be inappropriate when a supervisee is exploring an area for which she has a strong repertoire of knowledge. In that instance, a consultative role would be more useful.

Systems Approach to Supervision

The Systems Approach to Supervision (SAS) offers a multifaceted and intricate view of supervision. It takes into account a number of key phenomena and offers a conceptual map of how these interact in the supervisory relationship.

Holloway (1995, 2016) presented a comprehensive systems model. Her model provides a five by five matrix of functions and tasks. It comprises five functions, five tasks, and four contextual factors of supervision.

The five *functions* of supervision include: (a) monitor and evaluate, (b) instruct and advise, (c) model, (d) consult, and (e) support and share. The five tasks comprise: (a) counselling skills, (b) case conceptualization, (c) professional role, (d) emotional awareness, and (e) self- evaluation. The four broad contextual factors include: (a) the supervisor, (b) the supervisee, (c) the client, and (d) the agency or organization in which the supervision takes place. Table 2.3 presents the possible combinations of the five tasks and the five functions of the supervisor.

The functions and tasks of supervision are at the foreground of interaction, while the latter four dimensions represent unique contextual factors that are, according to Holloway, covert influences in the supervisory process. Supervision in any particular instance is seen to be reflective of a unique combination of these seven dimensions (Smith, 2009, p. 6).

The supervisor, at any given time in supervision, determines the task and function combination and proceeds with supervision through that framework. That is, the supervisor selects one task together with one

function and uses that combination to inform her intervention. Aasheim (2012) gives the following example:

> A supervisee is struggling to understand why he felt emotionally reactive with a client during a session. The supervisor determines that the intervention (a discussion) should focus on the task of emotional awareness as the supervisor would like to help the supervisee gain clarity about the emotional experience of that client, both in session and during supervision as he recollects the situation. The supervisor decides that a supporting and sharing function is most appropriate for this particular situation and believes that function will best help the supervisee make sense of his experience. So, the supervision process, at this point, is comprised of the task (emotional awareness) and the function (sharing and supporting). (p. 51)

Thus, as a supervision session unfolds, the supervisor will continue to identify tasks and determine a function and at the same time pay attention to the supervisory relationship. This relationship must remain strong and supportive to allow the interventions to be fully effective.

In the systems approach, the relationship between the supervisor and supervisee plays a central role (Morgan & Sprenkle, 2007) and is placed at the core of the model. Holloway (1995) proposes that the most important aspect of supervision is the relationship and it is within this relationship that all other components of supervision are experienced. Supervision mutually involves both members and aims to bestow power to both members.

Social Role Model

Williams' Social Role Model (1995) proposes four roles of the supervisor, namely teacher, facilitator, consultant, and evaluator. As teacher, the supervisor organizes the supervisee's didactic learning and in-service training. As facilitator, the supervisor helps the supervisee to become aware of her personal and interpersonal functioning and to bring this into her

awareness. As consultant, the supervisor discusses with the supervisee various assessment and counselling approaches and techniques and helps the supervisee to adopt those suited to her personal and professional functioning. As evaluator, the supervisor together with the supervisee evaluate the latter's learning process and progress using the various instruments available for this task.

Critical Events Model of Supervision

The Critical Events Model of Supervision was developed by Ladany et al. (2005). This model focuses on the relationship between supervision and the supervisee's development. This involves shifting between a focus on the supervisee's relationship with a client and the evolving relationship within supervision.

This model, also referred to as Events-Based Supervision Model (EBM), rests on the premise that most supervision focuses on the smaller events in a supervisee's work. This approach focuses on the supervisor's handling of events as they occur by drawing on the strategy of task-analysis. The EBM is a three-phase model.

The first phase of the supervisory model, named the *Marker*, entails the supervisee recognizing and expressing a problem or a critical event occurring in therapy (Ladany et al., 2005). An indicator or marker of a critical event (e.g., countertransference) is a statement by the supervisee such as "I get so angry with the client's demands." The authors describe seven critical events that commonly occur and are addressed in supervision. These include: "remediating skill difficulties and deficits; heightening multicultural awareness; negotiating role conflicts; working through countertransference; managing sexual attraction; repairing gender-related misunderstandings and missed understandings; and addressing problematic supervisee emotion and behaviors" (p. 19).

Table 2.2

Discrimination Model: A three by three grid of focus area and supervisor roles

Focus Area	Teacher	Counsellor	Consultant
Intervention Skills	Supervisee struggles to show immediacy with clients; Supervisor demonstrates immediacy in supervision.	Supervisee seems unable to challenge one of her clients.	Provides resources; brainstorms how to apply what he/she has learned in counselling.
Conceptualization Skills	Supervisee does not understand crux of client's problem.	Supervisee provides conceptualization of client; Supervisor helps Supervisee to conceptualize (e.g., fear, anger).	Supervisee expresses desire to know more about a technique; Supervisor provides resources and explains how to use them.
Personalization Skills	Supervisee treats client inappropriately.	Supervisor reflects supervisee's feelings, desires, and avoidances.	Supervisor is used as a sounding board for a Supervisee's attraction to a client.

Table 2.3

Holloway's tasks, functions, and contextual factors of supervision

Functions/Tasks	Counselling skills	Case conceptual-ization	Professional Role	Emotional Awareness	Self-evaluation
Monitor and Evaluate					
Instruct and Advise					
Model					
Consult					
Support and Share					
Contextual Factors	Supervisor	Supervisee	Client	Agency and organization	

The second phase of the model, called the *Task Environment*, consists of "a number of interaction sequences that involve supervisor operations and supervisee reactions" (Ladany, 2007, p. 340) for the purpose of resolving the critical event. Ladany reports that 12 common interaction sequences have been identified that include:

> a) focus on the supervisory working alliance, (b) focus on the therapeutic process, (c) exploration of feelings, (d) focus on countertransference, (e) attending to parallel process, (f) focus on self-efficacy, (g) normalizing experience, (h) focus on skill, (i) assessing knowledge, (j) focus on multicultural awareness, (k) focus on evaluation, and (l) case review. (p. 340)

For example, to facilitate supervisee insight, the interaction sequence might include focus on the therapeutic process, exploration of feelings, focus on countertransference, and attending to parallel process (p. 341). To assess interaction sequences and determine which sequence best facilitates the acquisition of a supervisee's skill, such as insight, Shaffer and Friedlander (2014) developed the Relational Behavior Scale that uses Ladany et al.'s (2005) operational definitions of the 11 sequences (p. 15).

The third phase of this model, *Resolution*, is the outcome of a particular event. Resolution of an event is thought of in terms of degrees, not absolute resolution. The model postulates four types of resolution, namely self-awareness, knowledge, skill, and the supervisory working alliance.

The processing of the critical events is embedded within the supervisory working alliance which is considered to be the foundation on which the event can or cannot lead toward a resolution. In keeping with Bordin's (1983) conceptualization of the supervisory working alliance model, Ladany et al. (2005) describe the supervisory working alliance as comprising three components: (a) a mutual agreement by supervisor and supervisee on the goals of the supervision, (b) a mutual agreement by supervisor and supervisee on the tasks of supervision, and (c) the formation of an emotional bond between supervisor and supervisee. Ladany (2007)

provides the transcript of a supervisory session wherein the supervisee was helped to gain insight into a critical event, namely countertransference. The interaction sequences comprised the following: focus on the therapeutic process, exploration of feelings, focus on countertransference, and attending to parallel processing.

Feminist approach to supervision

The first feminist approach to supervision appeared in an article by Wheeler et al. (1986). Feminist theory affirms that the personal is political, that is, an individual's experiences reflect society's institutionalized attitudes and values (Feminist Therapy Institute, 2009). According to Feminist Therapy Institute (2009), feminist therapists contextualize the client's and their own experiences "within the world in which they live, often redefining mental illness as a consequence of oppressive beliefs and behaviors (as cited in Smith, 2009, p. 3). Haynes et al. (2003) describe feminist therapy as "gender-fair, flexible, interactional and life-span oriented" (p. 122).

Feminism is seen to influence supervision in two broad ways. First, similar to other clinical supervision models (e.g., Cognitive-Behavioral Supervision), a feminist supervision model is a specialized method to train feminist therapists. Second, feminist supervision integrates feminist ideas and values (Prouty, 2001). The feminist model, which pays particular attention to encouraging a collaborative and egalitarian-learning relationship, saturates the process of supervision with feminist ideas and values. Five feminist concerns that played a key role in supervision were identified by Prouty (2001) in her study of feminist supervisors and supervisees. These were power inequities, gender issues, diversity issues, the role of emotion, and the role of socialization in people's lives. The purposeful focus on feminist values and on the quality of the supervisory relationship does not require that a supervisee be a feminist. These features have been adopted by many of the supervision models as can be seen in major texts that dedicate separate chapters on gender, power, relationships,

and diversity while integrating these issues throughout the text (Todd & Storm, 1997).

Systemic supervision

Systemic supervision is synonymous with family therapy and, similar to individual therapy, family therapy is characterized by a number of different theoretical orientations such as those of Bowen (1978), Satir (1988), Luthman (1975), and others. As in the case of individual therapy, the early systemic supervision models were based on a particular theory.

Systemic theories are characterized by attention to the dynamics of the interlocking systems. In systems theories, the therapist and their supervisors are "active agents of the system in which they are intervening" (Beck, Sarnat, & Barenstein, 2008, p. 80). System therapists and supervisors remain aware of the dynamics within the family system, between the family and the therapist, and within the supervisor-supervisee relationship.

Celano, Smith, and Kaslow (2010, pp. 36-41) outlined the essential components of an integrated couple and family therapy supervision. These include the following:

1. Developing a systemic formulation which refers to conceptualizing the problem in terms of multiple systemic processes (e.g., relationship patterns in the present and in prior generations; family development context; power dynamics; belonging and intimacy; sociocultural context; family routines and rituals; and family strengths) and theories about human development.
2. Forging a systemic therapeutic alliance which entails forming a therapeutic relationship with each member of the family.
3. Developing the skill of reframing which refers to defining or expanding the family's or couple's definition of the presenting problem to elicit more constructive and relational attributions. The reframing takes place within a given theoretical model and its purpose is to resolve problems more productively.

4. Helping the supervisee to manage negative interactions that occur within therapy, to build cohesion among family members, and to assist family in restructuring and parenting skills. These three competencies are considered to be the meat of family and couple therapy.
5. Understanding and applying evidence-based couple and family therapy models. This includes the skill to identify, evaluate, and apply evidence-based treatment strategies for any given case.

Process Model of Supervision

Hawkins and Shohet (1989) developed a double-matrix model of supervision which they called the Process Model of Supervision. The authors' double-matrix model of supervision involves two interlocking systems or matrices, namely the therapy system and the supervision system. The therapy system interconnects the therapist and the client through an agreed contract, shared task, and time spent together. The supervision system involves the therapist and the supervisor through their agreed contract, shared task, and time spent together.

The supervisory task is to pay attention to the therapy. Depending on how this attention is given, different supervisory styles emerge. The Process Model of Supervision divides supervision styles into two main categories. In Style One, supervision pays direct attention to the therapy matrix. In this style or approach to supervision, the supervisee and supervisor reflect on and review reports, written notes, or tape recordings of the therapy sessions. In Style Two, supervision pays attention to the therapy matrix "through how that system is reflected in the here-and-now experiences of the supervision process" (Hawkins & Shohet, 1989, p. 56). Each of these two major styles of supervision are further divided into three categories (modes) depending on the focus on the supervision process. The result is six categories (modes) of supervision that are summarized on Table 2.4. The three foci with their two modes are: client-focused supervision; therapist-client-focused supervision; and supervisee-supervisee-focused supervision. The authors

added a seventh focus or mode which is the context within which the therapist works (p. 75).

In their revised book, Hawkins and Shohet (2012) changed the name of their approach from the Process Model of Supervision to the Seven-Eyed Model of Supervision (p. 85). What was referred to as a focus or mode in their earlier model is now referred to as an eye; thus, there are seven eyes for the seven modes. The major difference in the revised book is it provides a more detailed description of the seventh eye, or the context within which the therapist works (p. 103). The three foci of Hawkins and Shohet's Process Model of Supervision and a demonstration of each are presented in chapter seven.

Table 2.4

*Process Model of Supervision: Two styles, their three categories, and six modes**

Style I. The therapy session is reported and reflected upon in the supervision	Style II. Focus on the therapy process as it is reflected in the supervision process
Mode 1. Reflection on the content of the therapy session: Attention is paid to what clients chose to talk about, how clients presented themselves, what they wanted to explore, and how the content of this session relates to content of the last session. The goal of this form of supervision is to help the therapist pay attention to the client.	*Mode 4. Focus on the therapist's countertransference*: The supervisor concentrates on whatever is still being carried by the therapist, both consciously and unconsciously, from the therapy session and the client. The supervisor distinguishes four types of countertransference: (a) transference feelings stirred up by a particular client; (b) feelings of playing the role transferred on him by the client; (c) feelings and thoughts used to counteract the client transference; (d) projected client material taken in mentally and psychically by the therapist
Mode 2. Exploration of the strategies and interventions used by the therapist: The goal of this form of supervision is to focus on the choices of interventions made and when and why they were made. Alternative strategies and interventions are developed and their consequences are anticipated. The main goal of this form of supervision is to increase the therapist's choices and skills in intervention.	*Mode 5. Focus on the here-and-now process as a mirror or parallel of the there-and-then process*: The supervisor focuses on the relationship in the supervision session in order to explore how it might be unconsciously playing out or paralleling the hidden dynamics of the therapy session (e.g., therapist playing out client's passive aggressive behaviour).
Mode 3. Exploration of the therapy process and relationship: The supervisor pays particular attention to what was happening consciously and unconsciously in the therapy process, how the session started and finished, and metaphors and images that emerged. The main goal of this form of supervision is the therapist gaining greater insight into and understanding of the dynamics of the therapy relationship.	*Mode 6. Focus on the supervisor's countertransference*: The supervisor primarily pays attention to their own here-and-now experience in the supervision, including what feelings, thoughts, and images the shared therapy material stirs up in them. The supervisor uses these responses to provide reflective illumination for the therapist.

*Reproduced from Hawkins & Shohet (1989, pp. 56-58).

Summary

This chapter presents models of clinical supervision which were classified as therapist-based models, developmental models, social role models, and process models. Social role models are considered to be atheoretical. But are supervision models actually atheoretical? Since clinical supervision entails working with psychotherapists who subscribe to a theoretical orientation, supervision by implication is also theoretically-oriented.

One goal of clinical supervision is to help the supervisee to apply the theoretical knowledge, assessment skills, and treatment interventions that she acquired in her training and practicum. To address these tasks requires special supervisory skills such as assessing the supervisee's level of development and attending to the supervisee's growth in self-confidence and autonomy. A second goal of clinical supervision is to help the supervisee enter into the profession of psychotherapy with its ethical, legal, societal and institutional requirements. The supervision models, taken as a whole, address the various components of supervision. That is, the models take into consideration the developmental stage of the supervisee, the various roles that the supervisor may assume, the supervisee competencies to be developed, and the focus of the actual therapeutic work. These tasks can be integrated to form a Four-Dimensional (4-D) Model of Supervision which includes development, social roles, competencies, and focus of therapeutic work. This model is presented in chapter seven.

The following chapter presents the ethical and legal foundations for supervision practice. It proposes an ethical decision-making model and outlines ethical principles specific to clinical supervision.

CHAPTER 3

Ethical and Legal Foundations for Supervision Practice

Clinical supervisors assume great responsibility in accepting to supervise the practice of supervisees. They are charged with training and developing their supervisees in three domains of professional functioning, namely ethical knowledge and behaviour, competency, and personal functioning (Lamb, Cochran, & Jackson, 1991).

To carry out their tasks, the clinical supervisor and supervisee rely heavily on codes of ethics and standards of practice to guide and inform their counselling practice and, most significantly, matters related to the supervisee's counselling practice. The supervisor must familiarize himself with all relevant laws of the land, codes of ethics, and standards of practice before entering into a supervision contract. The code of ethics and standards of practice provide the supervisor with important information regarding informed consent, supervisory relationship, endorsing a supervisee, and terminating a supervision contract (Aasheim, 2012, pp. 225-226).

However, research shows that supervisors are far from adhering to ethical guidelines. In one study, 51% of supervisees surveyed reported that their supervisors engaged in at least one ethical violation which is unacceptably extensive (Ladany, Lehrman-Waterman, Molinaro, & Wolgast, 1999). Such statistics highlight the importance of considering the ethical and legal aspects associated with supervision.

Clinical supervisors are responsible for ensuring that supervisees are aware of the practice expectations of their regulatory bodies and professional associations. When the supervisor belongs to a different

regulatory body and professional association than the supervisee, then special attention is required so that the standards of both regulatory bodies and associations are adhered to. The case becomes even more complex when supervision takes place within an agency that has its own requirements. In such situations, it is imperative that both the supervisor and the supervisee know the requirements of the agency and its procedures for managing clients. When there is a conflict between the agency's requirements and the standards of the supervisee's regulatory body, then the supervisee must adhere to the standards of the regulatory body. A regulated health care professional cannot use the agency's requirements as a reason to not adhere to the standards of the regulatory body. It is important, as well, that neither the welfare of the client nor the welfare of the supervisee be compromised.

Codes of ethics can be considered from two different perspectives. One perspective is to view the codes in terms of rules to live by and by which to conduct one's behaviours. This is the approach of the code of ethics of the American Psychological Association (APA, 2015). A second perspective is to emphasize the importance of ideals over rules and the importance of ethical decision-making. This is the approach adopted by the Canadian Psychological Association (CPA, 2009; Sinclair & Malone, 2014, p. 62). This code of ethics is considered to be "one of the most influential and well-respected psychological codes of ethics around the world" (Williams et al., 2012, p. 204).

This chapter presents codes of ethics and models of ethical decision-making and also addresses ethical domains specific to clinical supervision such as informed consent, confidentiality, and competency. It terminates by discussing multiple relationships and mentorship.

Codes of Ethics

Despite the different approaches to codes of ethics, moral principles undergird most codes of ethics. The Ethical Guidelines of Supervision in Psychology (CPA, 2009) is guided by four principles, namely I: Respect for

the Dignity of Persons, II: Responsible Caring, III: Integrity in Relationships, and IV: Responsibility to Society. Beauchamp and Childress (2001) list the four principles that undergird the code of ethics of the American Psychological Association (APA, 2002) and added a fifth. The five moral principles are: respect for autonomy (e.g., upholding the right for people to make their own choices); beneficence (e.g., contributing to the well-being of others); non-maleficence (e.g., not doing harm to others); justice (e.g., modelling fairness in distributing benefits and costs); and fidelity (e.g., keeping promises and not abandoning the supervisee) (Bernard & Goodyear, 2013, pp. 253-254). Examples of codes of ethics and their professional associations are:

1. American Association for Marriage and Family Therapy (AAMFT). (2012). *Code of ethics*. Alexandria, VA: Author.
2. Canadian Counselling and Psychotherapy Association (CCPA). (2007). *Code of ethics*. Ottawa, ON: Author.
3. Canadian Psychological Association (CPA). (2017). *Canadian code of ethics for psychologists*. Ottawa, ON: Author.
4. Canadian Psychological Association (CPA). (2009). Ethical guidelines for supervision in psychology: Teaching, research, practice, and administration. Ottawa, ON: Author.
5. Ontario College of Social Workers and Social Service Workers (OCSWSSW). (2008). *Code of ethics and standards of practice handbook.* Toronto, ON: Author.
6. The College of Psychologists of Ontario (CPO). (2008). *Standards of professional conduct*. Toronto, ON: Author.
7. The College of Registered Psychotherapists of Ontario (CRPO). (2014): Professional practice standards for registered psychotherapists. Toronto, ON: Author.

In addition to the codes of ethics that apply to the general practice of a psychologist or psychotherapist, there are other codes of ethics that apply to specific populations or to specific situations. Included among these are working with couples and families, teaching and conducting research, and

assessing for custody of children of divorcing parents. It is always important when a therapist or psychologist begins with a specialized population or situation to ask himself whether there are ethics and legal guidelines available. Examples of specialized codes are:

1. The American Association for Marriage and Family Therapy. (2015). Code of ethics. Alexandria, VA: Author.
2. American Psychological Association. (1994). Guidelines for child custody evaluation in divorce proceedings. Washington, D.C.: Author.
3. Canadian Psychological Association. (2009). Ethical guidelines for supervision in psychology: Teaching, research, practice and administration. Ottawa, ON: Author.
4. Duty to report under the child, youth and family services act (1990). Toronto, ON.

The ethical issues pertaining to the clinical supervision of supervisees concern informed consent, confidentiality, competency, and multiple relationships. This section begins with a presentation of several ethical decision-making models and then presents the particular ethical domains pertaining to supervision (Aasheim, 2012, pp. 227-244).

Ethical decision-making models

It is important for the supervisee to acquire the skills to deal with ethical dilemmas which often do not have clear-cut answers. There are a number of published models on ethical-decision-making which are helpful (Canadian Psychological Association, 2017; Canadian Counselling and Psychotherapy Association, 2007; Forester-Miller & Davis, 2016; Fisher, 2005; and Gondin, 2017). The models are not totally independent as they have borrowed ideas from earlier models. Three of these models are presented.

Canadian Psychological Association

The *Canadian Code of Ethics for Psychologists* (The Canadian Psychological Association [CPA], 2000) provides guidelines for making ethical decisions. These guidelines pertain to its four principles which are

briefly described. The four principles are given different weights of importance.

Foundational principles

Principle I: Respect for the dignity of persons and peoples: This principle upholds the inherent worth of all persons, their moral rights, and their right for distributive, social, and natural justice. This principle is given the highest weight with the exception of circumstances in which there is clear and imminent danger of bodily harm to a person.

Principle II: Responsible caring: Responsible caring requires competence, maximizing benefits, and minimizing harm and is carried out in ways that respect the dignity of persons and people. This principle is given the second highest weight.

Principle III: Integrity in relationships: This principle expects that psychologists demonstrate highest integrity in all of their relationships (e.g., openness). This principle is generally given the third highest weight. The exception in some circumstances concerns values (e.g., openness) which might be subordinated to values contained in principles I and II.

Principle IV: Responsibility to society: It is necessary and important to consider responsibility to society in every ethical decision; however, this principle needs to be subjected to and guided by the three previous principles. When there is a conflict between a person and the society and it goes unresolved, dignity, responsible caring, or integrity in relationships should not be sacrificed to a vision of the greater good of the society. This principle is generally given the fourth highest weight.

Steps in ethical decision-making

The Canadian Code of Ethics for Psychologists offers 10 basic steps to ethical decision-making regarding behaviour based on these principles. The following is a summary of the steps.

1. Identification of the individuals and groups potentially affected by the decision.
2. Identification of ethically relevant issues and practices, including the interests, rights, and any relevant characteristics of the individual and groups involved and of the systems or circumstances in which the ethical issues arose.
3. Consideration of how personal biases, stresses, or self-interest might influence the development of or choice between courses of action.
4. Development of alternative courses of action.
5. Analysis of likely short-term, ongoing, and long-term risks and benefits of each course of action on the individual(s)/group(s) involved or likely to be affected (e.g., client, client's family or employees, employing institution, students, research participants, colleagues, the discipline of psychology, society, self).
6. Choice of course of action after conscientious application of existing principles, values, and standards.
7. Action, with a commitment to assume responsibility for the consequences of the action.
8. Evaluation of the results of the course of action.
9. Assumption of responsibility for consequences of action, including correction of negative consequences, if any, or re-engaging in the decision-making process if the ethical issue is not resolved.
10. Appropriate action, as warranted and feasible, to prevent future occurrences of the dilemma (e.g., communication and problem-solving with colleagues; changes in procedures and practices) (CPA, 2009, p. 3).

The Ethical Code of Supervision in Psychology (CPA, 2009) is guided by the four principles referred to, namely I: Respect for the Dignity of Persons, II: Responsible Caring, III: Integrity in Relationships, and IV: Responsibility to Society.

Forester-Miller and Davis

Forester-Miller and Davis (2016) offer a seven-step ethical decision-making model. Their model is based on five foundational moral principles identified by Beauchamp and Childress (1979) and Kitchener (1984).

Foundational moral principles

The five foundational principals with a brief description are as follows: (1) autonomy – this addresses respect for independence and self-determination; (2) justice – this refers to treating equals equally and those who are not equal unequally but according to their relative difference, such as giving a blind person a form in braille rather than paper; (3) beneficence – this addresses the counsellor's responsibility to contribute to the welfare of the client by doing good, being proactive, and preventing harm; (4) nonmaleficence – this refers to not causing harm; and (5) fidelity – this involves the notion of loyalty, honesty, faithfulness, and honouring commitments (Forester-Miller & Davis, 2016, pp. 1-2).

Steps in ethical decision-making

Forester-Miller and Davis (2016) provide a seven-step model in ethical decision-making. The steps and a brief explanation of each follows.

1. Identify the problem – this implies being specific and objective in gathering as much information as possible; one may also ask is this an ethical, legal, clinical, or professional issue?
2. Apply a code of ethics – consider whether the identified problem is addressed by the code of ethics; one may have to consult more than one code of ethics such as the code of ethics for couple therapy if seeing a couple.
3. Determine the nature and dimensions of the dilemma – this includes examining the dilemma's implication for each of the foundational principles; determine which principle applies and takes priority; consult with an experienced colleague for their perspective.
4. Generate potential courses of action – brainstorm as many potential courses of action as possible; be creative and list all options; consult a

colleague to help you generate potential courses of action.
5. Consider the potential consequences of all options and determine a course of action – based on the information that has been gathered, evaluate each option; consider how the parties will be affected by the course of action; eliminate options, review the remaining options, and decide which option or combination of options to apply.
6. Evaluate the selected course of action – review the selected course of action to determine if it creates any new ethical considerations; review according to the principles of justice (i.e., is it fair and would you treat others the same way?); publicity (i.e., ask if you would want your behaviour reported in the press); and universality (i.e., would you recommend the same course of action to another counsellor?).
7. Implement the course of action – have courage to implement the course of action; do a follow-up after its implementation to determine if it has had the anticipated effect and consequences.

Pedro Gondim

Gondim (2017) offers a nine-step process in making an ethical decision.

1. Determine whether the issue is an ethical (and/or legal) issue.
2. Consult guidelines or standards that may apply to a specific identification and possible mechanism for resolution.
3. Consider as best as possible all sources that might influence the kind of decision you will make.
4. Locate and consult a trusted colleague.
5. Evaluate the rights, responsibilities, and vulnerability of all affected parties.
6. Generate alternative decisions and determine what additional information may be needed.
7. Evaluate the consequences of making each decision.
8. Make the decision.
9. Implement the decision.

Ethical principles specific to clinical supervision

Although the supervisor and supervisee are to be familiar with all articles of the codes of ethics pertinent to their practice, some of the articles have particular meaning to the supervisor and supervisee relationship. These include informed consent, confidentiality, competency, multiple relationships, and mentorship.

Informed consent

Supervisors are concerned with informed consent from two perspectives: (1) whether the supervisee is adhering to appropriate informed consent practices with his client, and (2) whether the supervisor is following appropriate informed consent practices with his supervisee (Aasheim, 2012, p. 233). The first point can be considered under two topics, namely informed consent with clients regarding their treatment, and informed consent with clients regarding supervision of their treatment (Bernard & Goodyear, 2014, pp. 257-260).

Informed consent with supervisees regarding their supervision

It is best practice for supervisors to inform supervisees about the processes and expectations of supervision and thereby obtain their consent. These can be accomplished by the use of a contract in which the supervisors clarify their gatekeeping responsibilities, the methods to be used in supervision, the time allotted for supervision, fees if applicable, required documentation, and whether there is a possibility that personal therapy will be recommended. With this information, the supervisee enters the supervisory experience knowing the conditions necessary for their success including the necessary personal and interpersonal competencies that they will be required to demonstrate (Bernard & Goodyear, 2014, p. 256). An example of what is to be included in a supervisor-supervisee contract is discussed in chapter seven.

Informed consent with clients regarding their treatment

Informed consent refers to a client's right to make decisions and willingness to enter treatment based on clear and transparent information

about the process. The legal features that pertain to informed consent are: (1) the client is capable of understanding the information and has the capacity to make an independent decision, (2) the client's consent is willing and voluntary, and (3) the client is provided with all of the necessary information to make a fully informed decision to consent to treatment (Knapp & VanderCreek, 2006). Haas and Cummings (1991) suggest seven categories of information, which, if provided, satisfy the requirements for sufficient informed consent. Four of these are: risk of treatment (e.g., to leave treatment without improvement); benefits of treatment; logistics of treatment (e.g., cost, length of treatment); and type of therapy that the client will be offered. The last three categories of informed consent are about supervision. These include how emergencies are managed (e.g., will the supervisor be available to the client?); the qualifications of the provider; and lastly, confidentiality.

Supervisors teach supervisees that informed consent is an ongoing process that occurs each time the treatment plan changes (Aasheim, 2012, pp. 233-234). That is, if a supervisee decides to change theoretical orientation from a cognitive approach to an attachment approach, the supervisee should clearly explain the implication of this to the client and obtain his/her consent.

Informed consent with clients regarding supervision

If the treatment provider is under supervision, it is imperative that he inform the client of the nature of the supervision procedures and be provided with information about how treatment and confidentiality will impact the supervision process. The client needs to know whether the sessions will be taped, who will watch them, and who is involved in supervision (e.g., one person, a team). A supervisor has the responsibility "to ensure that their supervisee is engaging in an appropriate informed consent process and is clear with clients that he is receiving supervision" (Aasheim, 2012, p. 234).

Confidentiality

Confidentiality between the client and supervisee is the substratum on which trust is established and the safe and secure atmosphere is created for open and honest sharing of meaningful material. It is imperative that the clinical supervisor assures the confidentiality of client material and confidentiality to the supervisee (Aasheim, 2012; Bernard & Goodyear, 2014).

Confidentiality to the client

Confidential materials include conversations between therapist and client, written documents, assessment records, intake and progress reports, and audio or video recordings. These materials are brought into the supervision; for this reason, the clinical supervisor has the responsibility to respect the confidentiality and privacy of the client. The client is to be informed at the outset of counselling of the supervisory relationship and how the material will be used and that both the therapist and supervisor have the responsibility to maintain the confidentiality and privacy of the client and of the client's material. The client must provide consent to share the information with the clinical supervisor which is usually indicated on the consent form. The clinical supervisor has the duty to take measures to keep all supervision notes in a secure place. If notes are electronically recorded and stored, they should be encrypted. It is good practice for the clinical supervisor to discuss ethical standards and confidentiality standards and laws with each supervisee and to ensure that clients are informed of practice policies regarding confidentiality and privacy.

Confidentiality to the supervisee

The supervisee is not entitled to the same tenets of confidentiality as clients. The clinical supervisor has, in this order, the responsibility to protect the client, the public, the profession, and the supervisee. The clinical supervisor has the responsibility to provide evaluative information to parties in addition to providing such information to the supervisee. The supervisee should be informed verbally and in the supervisee contract that information gathered during the supervision sessions can be shared to fulfill the

supervisor's protective responsibilities. The supervisor will only share information that relates to the supervisee's functioning and competence (Sherry, 1991). To minimize the negative reactions to such sharing, the supervisor can take the following steps: (1) make certain that supervisees are clear about the unique limitation of confidentiality in the supervision relationship; (2) make clear their order of responsibility to the supervisee both verbally and in the written contract such that the supervisor's responsibility, in order, are to the client, public, profession, and supervisee; (3) provide honest, clear feedback to supervisees when concerns begin to arise and continue after that; (4) discuss the matter, when possible, with the supervisee before sharing it with an outside source; (5) when the supervisor believes that evaluative information is to be shared, he should privately discuss this information with his supervisor or colleague who is skilled in supervision (Aasheim, 2012, p. 236).

Competency

Competence refers to having the necessary skills, knowledge, and capacity to undertake the tasks and functions considered necessary to the practice of a specific discipline according to the standards of that discipline (Falvey, 2002). Since competency is at the core of the professional code of ethics, it is incumbent that supervisors monitor their supervisee's scope of practice and competence as well as their own.

Supervisor competence

The clinical supervisor must have appropriate experience in the counselling profession and must possess specific training in the practice of clinical supervision (Harrar, VanderCreek, & Knapp, 1990). The Association for Counselor Education and Supervision (Dye & Borders, 1990) provides a standards statement that lists 11 "core areas of supervisor personal traits, knowledge, and competencies" (Aasheim, 2012, p. 228). These core areas are: thorough knowledge of various counselling theories and approaches; thorough knowledge of supervision models, approaches, and techniques; personal characteristics such as sensitivity to individual

differences, commitment to the role of supervisor, and a sense of humour; knowledgeable purveyors of the many ethical, legal, and regulatory aspects of counselling and supervision; and strong communication, evaluation, recording, and reporting skills (Aasheim, 2012, p. 228). The supervisor must always practice within the scope of his own training and experience. For example, a supervisor who is not trained to work with children is not qualified to supervise a supervisee's work with children whether the latter be trained or not trained to work with children.

It is also imperative that the supervisor take responsibility for his continued learning and development. This could come from incidental learning (e.g., knowledge that comes by chance); intentional and informal learning (e.g., knowledge that comes as we seek to understand a puzzling situation); and continued education activities (Bernard & Goodyear, 2014, p. 267).

Supervisee competence

In addition to being concerned about their own competency, supervisors must continually evaluate the competencies of the supervisees. Monitoring for competence constitutes the core of supervision practice. The clinical supervisor has the task to ensure that the supervisee is sufficiently able to provide competent service to the client and to help the supervisee to develop their counselling skills to increase their competence in all the domains of their practice. Falender and Shafranske (2004) developed a competency-based approach to psychology supervision that allows the supervisor to evaluate the skills and functions of psychology trainees through a formal rated process (see Appendix A). A trainee is ready to enter the field when all competence areas are solid enough to warrant greater autonomy (Aasheim, 2012).

Evaluating competence

Supervisees should clearly know how they will be evaluated and the instrument used for this should be noted in the supervision contract together

with a clear statement about practicing within the scope of one's training and practice. It is important for the supervisor to clearly articulate how he will evaluate the supervisee's competence.

In an educational setting, an instrument for evaluation might be provided. The same might be true if the supervisee is being supervised to meet the requirements for registration with a regulatory body such as The College of Registered Psychotherapists of Ontario (CRPO) and the College of Psychologists of Ontario (CPO). The CPO, for example, clearly states its requirements for certification which include: at least 1500 hours of supervised practice (usually within 12 months); passing a Jurisprudence and Ethics Exam; passing an Examination for Professional Practice in Psychology; and passing an Oral Examination. The CPO also provides a Primary (Secondary) Supervisor's Appraisal Form which indicates the areas that must be addressed in supervision and on which the candidate is evaluated. The CRPO specifies that registration requires 450 hours of direct client contact; 100 hours of clinical supervision; and passing a Registration Exam (e.g., the National Assessment). However, the CRPO does not provide explicit directions regarding the evaluation of the candidate's performance.

When clear guidelines for evaluation are not provided, the supervisor must determine which instrument he will use for the evaluative process. The supervisor might use published tools such as the Counseling Skills Scale (Eriksen & McAulife, 2003) or the Skilled Counseling Scale (Urbani et al., 2002). In place of these, the supervisor might create his own scale in keeping with the orientation of the supervision and the requirements of the regulatory body. By definition, clinical supervisors are "gatekeepers to the profession… and after a supervisee enters the profession, the supervisor serves as gatekeeper to the client or ongoing practice as a whole" (Aasheim, 2012, p. 232). It is important for the clinical supervisor to dutifully carry out his responsibilities as gatekeeper and, when required, request a supervisee to terminate his practice. This topic will be addressed again in chapter six.

Boundary violations and multiple relationships

Boundaries are ground rules for all professional relationships and include touch, self-disclosure, gifts, time, interpersonal space, and location. Boundaries can be avoided, crossed, or violated. Thus, a distinction is made between "boundary crossings" and "boundary violations" (Barnett & Molzon, 2014, p. 1058). Boundary crossings may clinically be appropriate while boundary violations by definition are harmful and unethical. For example, supervisors may appropriately use self-disclosure to enhance the value of the learning experience for the supervisee. Barnett and Molzon (2014) state that "crossings are defined by their clinical relevance, conformity with prevailing professional standards, being welcomed by the recipient, and being motivated by a desire to meet the other individual's clinical or supervisory needs, not by one's own personal needs or motivations" (p. 1058).

Multiple relationships are present when "a mental health professional is engaged in a secondary relationship with an individual with whom one has a professional relationship" (Barnett & Molzon, 2014, p. 1058). Thus, a clinical supervisor might have a financial relationship with a supervisee. Not all multiple relationships are patently forbidden, but those that hold potential for harm to or exploitation of the supervisee are to be avoided. Although some multiple relationships are unavoidable, such as in rural settings, all multiple relationships that are exploitative are to be avoided. Some multiple relationships may be beneficial to the supervisee. For example, a supervisor who has an evaluative role and who maintains responsibility for monitoring a supervisee's clinical activity might simultaneously be working with the supervisee on a research project.

Clinical supervisors, however, should disengage from any multiple relationships that could "impair their ability to be objective and provide honest evaluative feedback or are exploitative to the supervisees" (Aasheim, 2012, p. 240). Multiple relationships can cause difficulties in the supervision experience (Disney & Stephens, 1994) for the following

reasons: (1) the imbalance of power between supervisor and supervisee could result in diminished consent on the part of the supervisee who might find it difficult to agree or disagree with the supervisor, thereby creating difficulties; (2) the supervisor has the power to exploit the supervisee, such as a supervisee who rents space from the supervisor who wants to increase rent because the former's practice has grown, but the supervisee believes the rent is too much yet is powerless to discuss it with the supervisor; and (3) engaging in multiple relationships could create role conflicts, such as when the supervisor is both the clinical and administrative supervisor. The appropriate solution is to share the supervision with a colleague. Further to considering whether to supervise a supervisee working for an agency, the supervisor should consider carefully how he can exercise appropriate authority and power when necessary for the well-being and protection of the clients. The supervisor should work closely with the agency and determine how control will be shared (Aasheim, 2012, pp. 240-241).

One multiple relationship dilemma that is often present in the supervision relationship involves the boundary between providing supervision and providing psychotherapy (Barnet & Molzon, 2014, p. 1058). It is best practice not to serve in both roles simultaneously as there is a possibility that the supervisor will slowly over time shift from the role of a supervisor to the role of psychotherapist.

It should be noted that The Supervision Interest Network (Association for Counselor Education and Supervision [ACES] Supervision Interest Network) does not mandate a separation of administrative and clinical roles, but states:

> Supervisors who have multiple roles (e.g., teacher, clinical supervisor, administrative supervisor) with supervisees should minimize potential conflicts. When possible, roles should be divided amongst several supervisors. When this is not possible, careful explanation should be conveyed to the supervisee as to the

> expectations and responsibilities associated with each supervisory role. (Section 2.09)

Research demonstrates that supervisors and supervisees engage in high rates of dual relationships of a sexual and romantic nature. Such relationships are to be avoided. It is possible that romantic and sexual feelings may develop in the relationship; however, the supervisor must prohibit romantic and sexual behaviours from occurring and seek consultation or supervision around such issues (Aasheim, 2012, p. 241) so as to manage the feelings. If the feelings are not manageable, the supervisor must discontinue the supervisee and supervisor relationship.

Multiple relationships can also occur between supervisee and client. An example is borrowing money from a client or providing therapy to a family member. The more flagrant multiple relationship is having sex with a client. Such relationships must be prohibited. Ladany et al. (2005) observed in their study that approximately half of the supervisees who experience sexual attraction to clients will disclose it. The authors suggest that the topic of sexual attraction be introduced very early in supervision, as including such topics in an orientation to supervision normalizes these topics.

Mentorship

Is there a place for mentorship within the context of supervision, or does this indicate dual relationships? That is, can a supervisor play the role both of being a supervisor and a mentor to a supervisee? To respond to this question, it might be helpful to compare the definitions of supervision and mentorship. Bernard and Goodyear (2004) defined supervision as:

> An intervention provided by a more senior member of a profession to a more junior member or members of that same profession. This relationship is evaluative, extends over time, and has the simultaneous purpose of enhancing the professional functioning of the more junior person, monitoring the quality of professional

> services offered to the client . . . and serving as a gatekeeper of those who are to enter the particular profession. (p. 8)

By way of comparison, Johnson (2006) defines mentoring in its most simple form as:

> A personal and reciprocal relationship in which a more experienced faculty member [or clinical supervisor] acts as a guide, role model, teacher, and sponsor of a less experienced student [or supervisee]. A mentor provides the protégé with knowledge, advice, counsel, challenge, and support in the protégé's pursuit of becoming a full member of a particular profession. (p. 20)

The distinctive features of mentorship, according to Johnson (2007), are: (a) the mentor demonstrates greater achievement and experience in the profession, (b) mentorships are enduring personal relationships, (c) mentorships are reciprocal and become increasingly mutual as the relationship unfolds, (d) mentors provide protégés with both direct career assistance and social and emotional support, (e) mentors serve as intentional role models, (f) mentoring often results in an identity transformation in the protégé, (g) mentorships offer a safe harbour for self-exploration, and (h) mentorships are both highly beneficial and all too infrequent from the perspective of trainees (p. 260).

From these definitions and descriptions, it appears that supervision and mentorship are in many respects potentially complementary. Mentorship emphasizes support, encouragement, advocacy, and collegial connection. Supervision encompasses a distinct mandate for evaluation and gatekeeping. Supervision entails many roles on the part of the supervisor such as didactic expert, technical coach, role model, and evaluator. Supervision always concerns quality control such that clients receive acceptable care, supervisees are prevented from harming clients, and supervisees who lack sufficient skill or appropriate psychological fitness are referred for mediation (Johnston, 2007). Many models of supervision

underscore a collaborative working relationship being mindful of the developmental needs of the supervisees and the need to balance the sometimes-competing roles of the supervisor in the interest of the supervisee. As the supervisee matures and grows, there is a progression from "technical or transactional approaches to supervision" (e.g., development of assessment and counselling skills) to a "collaborative or transformational" approach (e.g., attending to supervisee's needs) to supervision which is likely more beneficial and personally meaningful to the supervisee (Johnson, 2007, p. 260).

As the supervision moves along the transactional and the transformational continuum, that is as supervision becomes more mentor-infused or transformational, there are several pragmatic and ethical issues that need to be addressed. Not all supervisors are meant to be mentors. Transformational supervision requires specific competence (e.g., dealing with added emotional complexity); careful attention to boundary maintenance; and gracefully balancing advocacy and evaluation (pp. 264-265).

Summary

This chapter emphasizes the importance for both the supervisor and the supervisee to be knowledgeable about the laws of the land, codes of ethics, and standards of practice relevant to the supervisee's clinical practice. The codes of ethics and standards of practice are understood as being helpful instruments that guide clinical practice. Regarding the codes of ethics, it is necessary to be familiar with the moral values that have influenced their development and not simply the socially acceptable behaviours. The chapter addresses aspects of the codes of ethics and standards of practice that are relevant to supervision such as informed consent, confidentiality, and competency. Multiple relationships, how to avoid them, and mentorship terminate the presentation.

The following chapter presents concurrent and ex-post facto methods used in making clinical material available for the purpose of supervision. The chapter also presents an array of interventions and techniques that can

be used in supervision to help the supervisee develop effective conceptual, therapeutic, and relational competencies and personal qualities. There is an emphasis on the development of the capacity to reflect on one's own performance in terms of understanding the client, determining a treatment plan, and identifying areas for further personal and professional growth.

CHAPTER 4
Methods and Techniques of Supervision

This chapter is divided into two parts. The first part presents the methods whereby the supervisor obtains information in order to help the supervisee to understand the client's problem, formulate a conceptualization, and plan treatment. At the same time, the supervisor uses the same information to evaluate the performance of the supervisee and the effectiveness of her treatment. The second part presents techniques and interventions that the supervisor uses to help the supervisee to develop conceptual and treatment skills, to grow in self-awareness, and to become more autonomous as a practicing therapist.

Part I – Methods of Supervision

Aasheim (2012) classifies supervision into two time-related groupings, namely "concurrent supervision" and "ex-post facto supervision" (p. 131). Concurrent supervision occurs at the time of the therapy session itself and includes methods such as live observation and live listening whereas ex-post facto supervision occurs after the therapeutic encounter. Aasheim favours the concurrent methods as they are less vulnerable to distortions found in supervisee verbal reports. The two time-related groupings of methods are presented under the headings of concurrent methods and ex-post facto methods. The current author adds a third category, namely pre-therapy briefing, under concurrent methods.

Concurrent methods of supervision

Concurrent methods of supervision refer to those methods that take place while the session is going on. These methods include live observation, live supervision, and reflection team. Pre-therapy briefing is included under this

section although it takes place prior to a therapy session. These approaches are briefly described.

Live observation

Live observation is a unidirectional process whereby the supervisor observes the supervisee doing real-time therapy with a client. The supervisor and supervisee do not interact during the counselling session. The supervisor might be watching a session behind a one-way mirror or through a closed-circuit television monitor. As the supervisor watches the session, she takes notes of the supervisee's performance and the interaction between the supervisee and the client. This type of supervision is favourable for several reasons: the supervisor can give feedback to the supervisee immediately following a session, the supervisor is present in case of an emergency, and the supervisor may invite other supervisees to observe the session. The supervisor can use the latter setting to provide instructional and observational feedback to the attending supervisees as the session occurs. The feedback needs to be given sensitively so as not to diminish the supervisee's trust of the process and the supervisor.

Live supervision

Live supervision refers to the supervisor providing feedback, guidance, or direction by intervening as the counselling session unfolds. The feedback is given to the supervisee. Live supervision can take many forms including co-therapy (in vivo supervision); supervisory entry; phoning in; bug-in-the-ear; bug-in-the-eye (e.g., monitor placed behind client's head on which supervisor writes notes for therapist); taking a break; or leaving the room for a consult (Aasheim, 2012).

Reflecting team

Andersen (1987), a Norwegian family therapist, coined the term-reflecting team. The practice evolved from his experience working in teams with family therapists. Family therapy has a long-standing tradition – originally developed in group clinical supervision settings – of drawing on

the input of a range of therapists who observe sessions through a one-way mirror.

A reflecting team is usually formed of a group of approximately four to seven therapists who observe a therapy session and then discuss what they noticed about the session. Reflecting teams can be utilized on a one-time basis as a way for a therapist and a client to obtain consultation on a case; alternatively, reflecting teams can be used as regular practice for therapists in training.

When a reflecting team is used, the client is introduced to all members of the team before the beginning of her session. This is followed by the therapist and client entering the therapy room for the session. During the course of the session, the reflecting team observes the session from behind a one-way mirror. After approximately 30 to 40 minutes, the client and therapist switch sides with the reflecting team. The client and the therapist watch through the one-way mirror as the team spends approximately 15 minutes discussing what they heard and observed. After this, the client and therapist switch sides again with the reflecting team and for approximately 10 minutes respond to comments from the reflecting team.

Pre-therapy briefing

Before a therapy session with a new client, the supervisor and supervisee meet to plan the strategy for an upcoming session. They review the information that the client gave when calling to arrange for an appointment. As well, they review options in terms of conceptualization and treatment approach and problems that might arise. The supervisee might express any concerns that she might have in seeing the particular client. The concerns are discussed.

In the case of an ongoing client, the supervisor and supervisee review the last session or sessions in terms of themes that were raised and worked on, counselling interventions that were used and how they were responded to by the client, and the therapist and client relationship. They spend some

time conceptualizing the client's concerns. Based on this review and the conceptualization, they anticipate themes that might emerge in the upcoming session and plan interventions to address the themes. If indeed an unexpected theme emerges, the supervisee is asked to explore it using basic interviewing skills and empathic responses. If a technique is to be used to bring about change, then the supervisor and supervisee review this technique in terms of its steps and/or procedures.

When meeting a client for the first time or when preparing to meet a client for the next session in ongoing therapy, the supervisee is asked to relate to the client in a friendly way and use her curiosity to explore a theme that emerges in the session or to apply a technique to bring about a change. The advantage of this method is that the therapist is asked to use her resources, step by step, in working with a client; in doing so, she builds self-confidence and develops her style of counselling.

Ex-post facto methods of supervision

Ex-post facto methods refer to those methods of supervision that use material produced either during the session or after the session. This material includes self-report, process and case notes, and audio or video tapings.

Self-reports

The most common method used in supervision is the self-report. A self-report is a narrative account by the supervisee of what transpired in the counselling session. As such, it is subject to distortion, bias, and inaccuracy (Aasheim, 2012, p. 129). Bernard and Goodyear (2014) concluded from their review of research that some of the best and some of the worst supervision can be found within the domain of self-report. The authors add that at its best,

> …self-report is an intense tutorial relationship in which the supervisee fine-tunes both case conceptualization ability and personal knowledge as each relates to therapist-client and

> supervisor-supervisee relationship. At its worst, self-report is a method where the supervisee distorts (rather than reports) his or her work, whether or not this is conscious. (p. 155)

Self-reports should not be used by themselves, particularly with novice supervisees, but in conjunction with other intervention methods.

Process and case notes

Process notes are the supervisee's written notes of the therapy session. The notes include an explanation (i.e., conceptualization) of the content of the therapy session, the pattern of interaction between supervisee and client, the supervisee's feelings about the client, and the manner of intervention and its rationale (Goldberg, 1985). Preparing process notes is very time-consuming and is seldom recommended although it is the norm for social work (Bernard & Goodyear, 2014, p. 156).

Case notes are normative for counselling and supervision. The case notes should encompass all aspects of the counselling session and include the interventions used. The supervisor can use the case notes to help the supervisee to reflect on and answer questions that meet supervision goals, such as the relationship between conceptualization and the choice of therapeutic interventions. Case notes should be used with other supervision techniques.

Several models for preparing cases notes have been proposed such as the PAIP and SOAP models (Martha St. Enterprises, 2009; Cameron & Turtle-Song, 2002). The acronym PAIP stands for Problem, Assessment, Intervention, and Plan and the acronym SOAP stands for Subjective, Objective, Assessment, and Plan. The definitions for components of the SOAP model and examples are summarized on Table 4.1. Martha St. Enterprises suggest that the PAIP and SOAP case notes follow an opening note which includes demographic information (e.g., client's age, gender); chief complaint stated in the words of the client; reported symptoms;

history (e.g., duration of symptoms); and mental status (e.g., cognitive and emotional functioning).

Recording review techniques

The use of audiotapes or videotapes can be very effective supervision tools. The use of audiotapes and videotapes can be made more palatable if the goals are determined for their use. They can be used in two different ways such as for the supervisor to listen to an entire recorded interview or to listen to segments of a recording.

It is important for the supervisor to listen to the recording of an entire first session or to a major part of the session before offering her feedback. To proceed this way is to provide the supervisor with a feel of how the supervisee conducts therapy and to gain an understanding of the supervisee's style of therapy. In understanding how the supervisee conducts therapy, the supervisor will be in a better position to help in the professional and personal development of the supervisee. An added reason for listening to an entire or a major part of a recorded session is to assure that the supervisee is "accurately identifying and bringing to supervision the key elements of the session requiring expert feedback" (Love, Davis, & Callahan, 2016, p. 19). Further, the supervisor is not in a position to logically infer that a supervisee is ready for "less intense and/or close supervision until the supervisor has consistently observed the trainee correctly identifying their needs for supervision across a range of client presentations" (p. 19).

A second usage is for the supervisee to present a section of the tape to introduce the client to the supervisor, to test a hypothesis, and to check for patterns and for the supervisee to demonstrate where she performed well or a segment where she had difficulty and wants some input. One of the uses of this media is to *introduce the client*. The supervisor can see firsthand how the client presents herself – tone of voice, posture, dress, affect, etc. A second goal might be to *test a hypothesis* regarding assessment, diagnosis, use of specific intervention, or treatment. It might also be used to try to

understand why a client does not seem to open up during therapy or why another client tries to control the session and what technique works best to take this effort away from the client. A third goal is to *check for patterns*. The supervisor and supervisee might select a certain segment of the tape and ascertain the supervisee's pattern and then select other segments to see if that pattern is repeated. Thus, one can use the tapes to ascertain the supervisee's behaviour patterns such as not challenging a client, avoiding exploration of feelings of anger, and not addressing dependency needs (Aasheim, 2012, pp. 182-183).

Table 4.1
Summary of SOAP definitions and examples

Section	Definition	Examples
Subjective (S)	What the client tells you What pertinent others tell you about the client Basically, how the client experiences the world	Client's feelings, concerns, plans, goals, and thoughts Intensity of problems and impact on relationships Pertinent comments by family, case managers, behavioural therapists Client's orientation to time, place, and person Client's verbalized changes toward helping
Objective (O)	Factual: what the counsellor personally observes/witnesses Quantifiable: what was seen, counted, smelled, heard, or measured Outside written materials received	The client's general appearance, affect, behaviour Nature of the helping relationship Client's demonstrated strengths and weaknesses Test results and materials from other agencies are to be noted and attached
Assessment (A)	Summarizes the counsellor's clinical thinking A synthesis and analysis of the subjective and objective portion of the notes	For counsellor: include clinical diagnosis and clinical impressions (if any) For care providers: how would you label the client's behaviour and the reasons (if any) for this behaviour?
Plan (P)	Describes the parameters of treatment Consists of an action plan and prognosis	Action plan: include interventions used, treatment progress, and direction. Counsellors should include the date of next appointment. Prognosis: include the anticipated gains from the interventions

Adapted with permission from Susan Cameron and Imani Turtle-Song (2002), p. 290.

The supervisor might also ask the supervisee to transcribe a section of the audio or video tape in order to help the client with a specific aspect of a therapeutic intervention. For example, for a supervisee who is having difficulty formulating empathic responses, the supervisor can suggest that for a given number of client statements, for example four to six statements, the supervisee is asked to provide an empathic response.

Part II – Supervision Techniques and Interventions

Heron (1974) found a way to classify all supervisor interventions in any facilitating or enabling process into six categories. The interventions apply equally to one-to-one and group situations. The list is thought not to be exhaustive but helpful to think about the interventions that one uses and is comfortable with. The definitions emphasize the effect that the intervention has on the client. The categories with brief definitions are: (1) Prescriptive (e.g., give advice, give directions; (2) Informative (e.g., be didactic, instruct, inform); (3) Confrontative (e.g., be challenging, give direct feedback); (4) Cathartic (e.g., release tension, abreaction); (5) Catalytic (e.g., be reflective, encourage self-directed problem-solving); and (6) Supportive (e.g., be approving, confirming, validating) (Hawkins & Shohet, 1989, p. 85). The authors note that the six types of intervention have real value only when rooted in care and concern for the supervisee.

This section presents the interventions that appear most frequently in the literature. The supervisor has available to her a repertoire of techniques that can be used in the course of supervision to help the supervisee develop a more complete understanding of the client and to help her with the continued development of assessment and therapy skills to serve the needs of the client.

Supervisors select their techniques based on what they believe is most effective to provide client care and at the same time develop the supervisee's skills. In choosing the techniques, the supervisor must take into consideration the supervisee's level of development, her theoretical orientation, her personality characteristics, and the specific needs of the client. The techniques presented here may also help to develop the supervisee's ability to self-reflect. Aasheim (2012), Bernard and Goodyear (2014), and Overholser (2004) suggest several techniques.

Developing a positive collaboration between supervisee and supervisor

The supervisor's first priority in supervision is to establish a positive collaborative relationship with the supervisee. The supervisor should constantly monitor the quality of the supervisory relationship (Safran & Muran, 2001).

Effective supervisors are respectful and encouraging (Watkins, 1997), and create a safe and supportive environment (Emerson, 1996). Supervisees tend to be appreciative when supervisory sessions include a positive exchange of ideas and information. Whenever possible, supervisees should be praised for areas of strength, growth, and maturity. Positive reinforcement can help to bolster the skills that are already possessed by the supervisee. Most supervisees are apprehensive about the evaluative nature of psychotherapy supervision.

Supervisees are still in the training stage of their career, and they are learning basic skills, general theories, and simple applications. The closer they are examined, the more insecure most supervisees will become. It is often useful to ask supervisees to audiotape their psychotherapy sessions and let the supervisor listen to the tape prior to the supervision meeting (Liese, 1998). Supervisees are often anxious about the supervisor's evaluation, especially when their psychotherapy sessions have been audiotaped or videotaped. While listening to a taped session, the supervisor may take detailed notes about the session and could become overly critical and dogmatic in supervision. The supervisor must be sure to include mention of positive qualities that were displayed by the trainee during each psychotherapy session. Supervision can be used to promote a realistic self-evaluation of therapy skills.

Unfortunately, many supervisees tend to evaluate their performance in a weak manner, stating "I guess I didn't mess up," or "The session went okay despite me." Trainees are often insecure and want to be liked and respected by their supervisor (Atkins, 2001). It is important for the supervisor to help reduce the anxiety in the trainees (Cresci, 1996). Some of their anxiety can be reduced by frequent praise for any appropriate behaviours they have

displayed in session. Also, respect and acceptance are central ingredients of effective supervision (Frankland, 2001).

When asked to describe "good supervision," many trainees emphasize the importance of frequent positive feedback. It is often useful to emphasize a teamwork approach to supervision (Henderson, Cawyer, & Watkins, 1999). The client's well-being is entrusted to two individuals: supervisor and supervisee. Together, they can derive an effective treatment plan and monitor progress over time. Also, trainees appreciate it when their supervisor demonstrates that supervision is a priority, making the time to meet each week, regardless of other constraints on a busy schedule. It can be useful to inform supervisees of the different perspectives that are obtained from the role of supervisor instead of therapist. Many events can be interpreted in a more objective manner when viewed from the role of supervisor, when one is not distracted by the front-line events that occur in the therapy session. For example, during supervision, a trainee described a client's problems relating to adult females. Earlier sessions had examined relationship problems with the client's mother. The supervisor helped to identify and appreciate the recurrent pattern across the client's disturbed interpersonal relationships. As the supervision continued, it became easier for the trainee to see the developmental origins of the dysfunctional attachment patterns (Overholser, 2004, pp. 4-6).

Self-reflective process

Within the context of psychodynamic psychotherapy, Sarnat (2010) considers the four key competencies to include relationship, self-reflection, assessment-case conceptualization, and intervention (p. 20). Of these competencies, self-reflection is a complex and highly developed process. As supervisees become more autonomous and independent, they need to develop the ability to critically examine and evaluate their work and the impact of their work. That is, they need to develop the ability for self-reflective thinking or reflectivity.

This section provides a description of self-reflective process, how the supervisor and supervisee collaborate to develop it, and barriers to its development. The reader may read a succinct article on these topics presented by Orchowski, Evangelista, and Probst (2010).

Description of the self-reflective process

Rodolfa and associates (2005) defined reflective-self-assessment as "practice conducted within the boundaries of competencies, commitment to lifelong learning, engagement with scholarship, critical thinking, and to the commitment of the development of the profession" (p. 351). From a psychodynamic perspective, however, "self-reflection competence requires a highly developed capacity to bear, observe, think about, and make psychotherapeutic use of one's own emotional, bodily, and fantasy experiences when interacting with a client" (Sarnat, 2010, p. 23). Kaslow, Dunn, and Smith (2008) view reflective practice-self-assessment in terms of self-reflection and self-care. Self-care competence includes "developing the capacity to honor and feel compassion for one's own needs/feelings/emotions even when consultation is not immediately available" (Sarnat, 2010, pp. 23-24). Neufeldt, Karno, and Nelson (1996) provided the following description of the reflective process:

> The reflective process itself is a search for understanding of the phenomena of the counseling session, with attention to therapist actions, emotions, and thoughts, as well as to the interaction between the therapist and the client. The intent to understand what has occurred, active inquiry, openness to that understanding and vulnerability and risk-taking, rather than defensive self-protection, characterizes the stance of the reflective supervisee. Supervisees use theory, their prior personal and professional experience, and their experience of themselves in the counseling session as sources of understanding. If they are to contribute to future development, reflections must be profound rather than superficial and must be meaningful to the supervisees. To complete the sequence,

> reflectivity in supervision leads to changes in perception, changes in counseling practice, and an increased capacity to make meaning of experiences. (p. 8)

Aasheim (2012) states that self-reflective thinking is an ongoing process of a counsellor examining her theories, beliefs, and assumptions that influence her conceptualization and interventive choices. For a supervisee to become engaged in a self-reflective process, she must be confronted with a dilemma, or some sort of confusion for which she intends to search for a solution (p. 177).

Developing self-reflective competency

The ability to self-reflect builds a counsellor's procedural knowledge and understanding of the counselling process and at the same time amplifies the counsellor's ability to understand how affective and cognitive experiences inform and are informed by client-counsellor interaction (Aasheim, 2012; Orchowski et al., 2010). Supervisors assist supervisees in developing self-reflective practice so that they can effectively self-supervise. The ultimate goal of supervision is for the supervisee to internalize the process and make decisions that "optimize client care and fully engage one's most competent skills" (Aasheim, 2012, p. 177).

Role of supervisor in reflectivity: In order for the supervisor to provide mentorship and instruction to the supervisee, the supervisor must engage in her own personal self-reflection. This includes developing an awareness of the cultural background of the client, the supervisee, and the supervisor (Orchowski et al., 2010).

The supervisor who trains supervisees in a culturally component (setting) must be able to withstand feelings of vulnerability associated with their own disclosure of their ethnic and racial identity. As well, it is important for the supervisor to model reflective dialogue with the supervisee. She can do this by reflecting directly on her own cognitive or emotional experiences as they arise in the supervision session. When modelling reflective-practice, the

supervisor aims “to confront puzzling interpersonal or affective events, explore the dynamics behind the event, and work toward resolving the puzzling event so that they can apply new knowledge in future practice situations” (Orchowski et al., 2010, p. 55).

The supervisor can also use communication strategies that stimulate reflectivity to help supervisees systematically develop theoretical knowledge and apply procedural knowledge according to the affective feedback from the client. The strategies that the supervisor can use include Socratic questioning as well as open-ended and non-judgmental questions (see below for different types of questioning).

In-session activities to promote reflectivity: One of the techniques that can be used is interpersonal process recall (Kagan, 1980; Elliott, 1986). This entails the supervisee and the supervisor to review a tape and identify a puzzling section or a compelling portion of the session. The person who stopped the tape begins a discussion about this portion of the session and indicates why it is relevant to the person.

Outside-of-session activities to promote reflectivity: There are several tasks that a supervisee may perform between sessions to develop the ability for self-reflection. One method is to reflect on a dilemma that occurred within the session. A person may reflect on the dilemma by responding to a series of questions such as those prepared by Neufeldt (1999). Another useful tool is journaling which can be structured in terms of how to provide feedback on journal activities. The supervisor facilitates the development of reflectivity not by providing answers, being directive, and teaching, but by engaging the supervisee in a “process by which they have to look inward and produce their own thoughts, evaluative feedback, and solutions” (Aasheim, 2012, p. 177).

Barriers to developing self-reflective competency

To engage in self-reflection requires being vulnerable. Barriers that are specific to the supervisor relationship might include a large power

differential between supervisee and supervisor, or the supervisor having a dual relationship with the supervisee (e.g., thesis advisor and providing clinical supervision). To foster a supportive supervisory atmosphere conducive to self-reflection, it is necessary to clarify, minimize, or avoid the dual relationship. It is necessary for the supervisor to maintain clear boundaries with the supervisee, to build and maintain an alliance with their supervisee, and to provide a warm and supportive atmosphere to allow for strong rapport and rebuilding of alliance ruptures (Orchowski et al., 2010, p. 61).

Some barriers on the part of the supervisee to self-reflection include performance anxiety and feeling incompetent. A key barrier to establishing an open supervisory dialogue is for the supervisor to underestimate the extent of the supervisee's anxiety about participating in clinical supervision. For this reason, it is important to establish a positive and supportive atmosphere. As well, setting boundaries around the supervision relationship enables supervisees to feel comfortable with expressing vulnerability during supervision. The approach that the supervisee takes to self-reflection is a critical factor to determine whether she will adopt a reflective stance.

A second supervisee barrier to self-reflection is the feeling of being incompetent. Such a supervisee might withdraw from engaging in self-reflection with their supervisor. She might believe that she is not able to generate knowledge on her own and consequently passively withdraw from self-reflection. Such withdrawals may allow the supervisee to feel safe by avoiding the possibility of providing an incorrect answer, but this behaviour is detrimental to reflectivity because it thwarts the supervisee's ability to remain affectively connected to the supervision experience (Orchowski et al., 2010, p. 62).

In brief, self-reflective practice, in supervision, "means that the supervisor is assisting the supervisee in reviewing and considering his work from a self-evaluative lens. The supervisee considers the multitude of

features that contributed to his choices and considers the impact of those choices on all parties" (Aasheim, 2012, p. 177).

The Socratic method: Systematic questioning

Socratic questioning can be used to facilitate supervisee self-reflection. The goal is not the answer, but the search for an answer. The supervision session should be used to explore the supervisee's ideas, reflections, and plans. The Socratic method can provide a framework to guide the supervision sessions and foster supervisee growth and development. The Socratic method involves several overlapping components that include systematic questioning, inductive reasoning, and a disavowal of knowledge. These elements, when combined, can help the supervisor guide the dialogue toward exploration and development (Overholser, 2004, pp. 7-8).

Systematic questioning

Systematic questioning can provide structure for supervision sessions. The questions should derive from a sincere search for information and not resemble an interrogation of the supervisee. The goal of the dialogue is to foster the supervisee's ability to anticipate and prepare for certain events within the psychotherapy sessions. When done effectively, "the supervisor's questions propel the dialogue ahead, while the supervisee's answers steer the discussion toward one path or another" (Overholser, 2004, p. 8). It is important to help trainees develop clear and logical thinking regarding clinical issues, such as setting therapeutic goals, determining priorities, and evaluating the effectiveness of an approach. A supervisor might ask several different types of questions such as memory, translation, interpretation, application, analysis, synthesis, and evaluation questions (Overholser, 1993; Aasheim, 2012).

Memory questions involve the supervisee recalling historical information such as "How did the client greet you when she came into your office … [and] how did the greeting impact the tone of the session?" (Aasheim, 2012,

p. 176). The focus of recall is not on the fact, but on the impact or meaning of the events.

Translation questions can be used to help trainees generate a variety of new ideas or meaning of information and identity to fill in the gaps in the supervisee's understanding of the information. For example, it can be useful to ask "How would Albert Ellis deal with this situation?" or "What would Carl Rogers say about this session?" (Overholser, 2004).

Interpretation questions invite the supervisee to discover relationships between various aspects of an issue with the goal of using one's prior knowledge to bring meaning to something that is current (Overholser, 1993). For example, a supervisee might report that she feels very uncomfortable seeing a client that wants to control what happens in therapy. When asked whether this reminds her of something, she adds that it reminds her of a controlling client she saw a year ago. She then realizes that the client of a year ago was not as controlling as it appeared. This helps her to relate to her current client.

Application questions invite supervisees to use knowledge and skills that they already possess to deal with a current issue (Overholser, 1993). The supervisor might use brief questions to facilitate problem-solving by asking questions such as "What have you tried thus far?" or "What other options do you see?" In solving problems, it is important to be aware of the stages of problem-solving so that the questions can be appropriately asked. The stages in problem-solving include problem definition, generation of alternatives, decision-making, and implementation/evaluation of the selected strategies (Overholser, 2004).

Analysis questions used on the part of the supervisor are designed to help the supervisee break down a problem into more manageable pieces. The focus of such questions is to have the supervisee engage in the thinking process to examine a problem and then draw logical conclusions. Such questions are appropriate when the supervisee might have drawn an inappropriate conclusion. For example, a supervisor might ask a supervisee,

“What evidence do you have that leads you to say that the client is trying to control you?” This could be followed by, “What else could be happening?” (Aasheim, 2012, p. 179).

Synthesis questions invite the supervisee to solve problems by using creative and divergent thinking (Overholser, 1993). The purpose is to invite the supervisee to find a wide range of answers and solutions. For example, the supervisor might ask, “What might be another approach, other than confrontation, when working with the dependent client?” (Aasheim, 2012, p. 179).

Evaluation questions invite the supervisee to make a value judgment against a specific standard (Overholser, 1993). In this case, a standard is identified, and then a judgment is made using that standard. Aasheim gives the following example:

> The supervisee states, ‘I’m not good at working with highly depressed clients. They just won’t talk to me!’ The supervisor asks the supervisee to describe the typical relationship between someone who is very depressed and a new person who enters their life. The supervisee recognizes, ‘Oh, I guess when you’re really depressed it is hard to really feel excited about meeting anyone new.’ (p. 180)

Inductive reasoning

Inductive reasoning involves “drawing general conclusions from specific events” (Overholser, 2004, p. 9) and thereby it transcends personal experiences. Analogies can be used to help to understand a new problem or concept referring to something that is known. In this way knowledge is transferred from familiar situations to novel situations. For example, to understand Freud’s term Superego, the supervisee might be asked to consider the roles that parents play in the life of a child which include both prohibiting certain behaviours and providing goals and ideals to live by.

A disavowal of knowledge

Socratic ignorance "relies on the genuine acknowledgement of limitations in the supervisor's knowledge" (Overholser, 2004, pp. 9-10). The supervisor should be open to learning, acknowledge her limited knowledge, be intellectually honest, express a desire to learn, and engage in collaborative investigation. An honest disavowal of knowledge fosters collaboration between the supervisee and supervisor. Even if the supervisor's treatment plan is correct, it is preferable to explore a variety of issues and at the same time provide the supervisee with opportunities to learn and to grow.

Use of linking and generalization questions

Supervisors may find that they do not have the time to engage in an in-depth discussion with the supervisee for each of the clients but may want to use questions that allow the supervisee to consider many clients at once. In such situations, the supervisor may choose to use generalization or linking questions to engage the supervisee in critical thinking and reflection about more clients than the one being addressed (Aasheim, 2012, p. 180). This amounts to a general discussion regarding approaches across clients.

Generalization questions have the goal to invite the supervisee to consider other clients that might benefit from the solutions considered during the reflective process. For example, if a cognitive approach is chosen for a client who does not want to engage in analysis of subjective experiences, one can ask for which other clients might such an approach be appropriate.

Linking questions invite the supervisee to consider other clients who have had similar issues. The supervisee is asked how such clients resolved such issues and how that solution might be used with this particular client.

Providing directive guidance

Some supervisees, at certain times, benefit from a fairly directive approach to supervision and this is particularly true when working with difficult clients and when confronted with difficult emotional situations in

therapy (Overholser, 2004, p. 6-7). For example, when working with clients struggling with abandonment issues, an explanation about the origin of abandonment and process of working through it can be helpful to the supervisee as it serves as a map. Brief didactic presentations can be useful for novice supervisees who are eager to learn basic skills. These presentations can be complemented by suggesting books and articles that could facilitate the supervisee's work with a particular client. When providing direct guidance, it is helpful to keep it simple and focused. For example, the general goals of an intake session can be "summarized as (1) gather information regarding the client's symptoms, prior treatments, and possible diagnosis, (2) establish rapport with the client, and (3) instill realistic hope in the client's ability to benefit from additional therapy sessions" (Overholser, 2004, p. 7).

Representational chair

The representational chair is simply an extra chair that is present in the supervision space and represents the presence of the client in the supervision room (Aasheim, 2012, p. 184). When discussing the client and having made statements about her, the supervisor might ask the supervisee how the client might respond to what was discussed, planned, and hypothesized. The representational chair makes the discussion about the client more real as it is as if the client is in the supervision space. The representational chair is reminiscent of the Gestalt empty-chair technique but the former differs from the latter in that it is not conducted with the "same type of planning, practicing and curative effect" (Aasheim, 2012, p. 185). The techniques used with the representational chair are more spontaneous and can be used by either the supervisor or the supervisee.

The supervision genogram

The supervision genogram "is a symbolic representation of supervisee's supervision relationships and experiences" (Aten & Madison, 2008, p. 110). The goal of the genogram is to bring to awareness complex patterns and influences which may promote self-reflection, self-awareness, and an

understanding of the supervisory process. In addition, this supervision tool might help supervisees to recognize the impact that these prior relationships might have on current professional relationships and roles. Genograms are apt to help a supervisee understand a client within a broader context.

The supervisee can be instructed to complete the exercise in a time-limited manner (e.g., 30 minutes) and discuss this genogram later in supervision. The supervisee is to note all professional supervision relationships (using synonyms to protect confidentiality) using agreed upon symbols for the diagram. The supervisee could be given a completed supervision genogram with its symbols and brief summary. The supervisee is asked to reflect upon the genogram to identify themes and patterns across supervisory relationships and experiences.

To draw a supervision genogram, the supervisee begins by drawing a horizontal line across the page which represents a timeline of training experiences listed in chronological order. Practicum supervisors can be drawn above the line and field or work supervisors can be drawn below the line. After the genogram has been completed, the supervisor might discuss it with the supervisee in a time-limited manner (e.g., 30 minutes) (Aten & Madison, 2008, p. 112).

The genogram may also be used to describe a case so as to better understand patterns and influences of current and prior relationships. Genograms are particularly helpful when providing supervision of family therapy to reveal the emotional processes and structures within a family as well as intergenerational patterns (Kerr & Bowen, 1988).

Homework

Following a supervision session, the supervisor might suggest some form of homework such as “post-counselling session reflection prompts” (questions) or “journaling” (Aasheim, 2012, p. 186). The supervisor might provide a series of questions that the supervisee is to respond to following a therapy session. The questions are designed to explore the various aspects

of the therapy session such as cognitive, affective, motivational, and behavioural features, and decision-making, theory-based, and interpersonal aspects of the session.

As for journaling, the supervisee might be asked to enter their reflections in a journal or a log following a session. These may be paper journals or letters that the supervisee brings to the supervision. The reflections might also be posted to a private discussion board, a chat room, or via e-mail (Aasheim, 2012, pp. 186-187). The supervisee might also keep a second file for each client and in the file enter the reflective thoughts, assessments, and future plans for therapy. As well, the supervisee might ask questions or hypotheses to be checked out in future sessions.

Individual customization of tasks and techniques of supervision

It is imperative that the supervisor customize the supervision to match the specific needs and styles of each supervisee and to "adapt the style, focus, and expectations to match the level of training, experience, and skill of the supervisee" (Overholser, 2004, p. 10). As well, supervision should be customized according to the developmental level of the supervisee; her theoretical orientation, personality, and cultural background; and the specific issues pertaining to the client. As the supervisee progresses from novice to intermediate levels of skill (Stoltenberg & Delworth, 1987), for example, the style of supervision can change as well. When supervising a novice level supervisee, the supervisor is apt to be more acting and leading. As the supervisee matures, the supervisor can reduce the amount of direct monitoring and guidance and increase the level of challenge in supervision (Overholser, 2004).

Developmental progression of supervisees

The methods and techniques of supervision have the goal of the supervisee progressing from being a beginning supervisee to becoming an advanced supervisee. How can these methods and techniques be implemented to facilitate the development of the supervisee? Barnett and

Molzon (2014) provide an approach for how some of these methods and techniques can be used in supervision to facilitate the developmental growth of the supervisee. The approach is presented in six nodal points of supervision.

1. The supervisee observes the clinical supervisor provide a particular skill (e.g., an intake interview).
2. The supervisor and supervisee engage in a role-play of a particular clinical service (e.g., ego state therapy) during individual supervision.
3. If possible, the supervisor and supervisee jointly provide a clinical service.
4. The supervisor observes the supervisee providing clinical service and shares feedback and suggestions in real time.
5. The supervisee video records or audio records the provision of a clinical service and provides the videos and documentation to review prior to the supervision session.
6. The supervisee selects audio and/or video recording for intensive review in clinical supervision.

Summary

This chapter presents methods that the supervisor may use to obtain information in order to help the supervisee understand the client's problem, formulate a conceptualization, and plan treatment. These same methods may also provide material to assess the performance of the supervisee. The methods are grouped according to concurrent methods such as live observation, live supervision, and reflecting team and ex-post facto methods that include self-reports, case and process notes, and audio and video recording. The preferred methods for obtaining information include live observation, live supervision, and audio and video recording as these methods provide reliable material to carry out the supervisory functions.

The methods and techniques that the supervisor might use to help the supervisee develop conceptual and treatment skills, grow in self-awareness, and become autonomous as a practicing psychotherapist are also presented.

It is of great importance that the supervisee engage in an ongoing self-reflective process which examines her theories, beliefs, and assumptions that influence her conceptual and intervention skills. It is also essential for her to examine her own feelings, thoughts, and needs to determine how they impact the therapy process. It is through self-reflective process that the supervisee moves towards autonomous and independent practice.

In brief, it is of utmost importance that the supervisor customizes the supervision to match the specific needs and styles of each supervisee and to adapt the style, focus, and expectations to match the level of training, experience, and skill of the supervisee. As well, supervision should be customized according to the developmental level of the supervisee; her theoretical orientation, personality, and cultural background; and the specific issues pertaining to the client. The following chapter addresses the task of evaluating the performance of the supervisee and her readiness for independent practice.

CHAPTER 5
Evaluation Process and Supervision

The supervisor has a responsibility to the profession; to the supervisee's clients, today and in the future; and to the institution if service is provided to it. This responsibility is known as the gatekeeping function. Evaluation concerns the supervisee's growing knowledge of acceptable ethical and legal behaviours, development of relationship skills, clinical competency, and personal growth to provide services to clients. The topics of this chapter include types of evaluation, criteria for evaluation, favourable conditions for evaluation, and negotiating the process of evaluation.

Types of evaluation

Robiner, Fuhrman, and Ristvedt (1993) differentiate between *formative evaluation* and *summative evaluation*. Formative evaluation is described as the process of facilitating the skill acquisition and professional development through continued feedback. This form of evaluation "does not feel like evaluation because it stresses the process and progress of professional competence, rather than outcome" (Bernard & Goodyear, 2014, p. 223). It is important to remember, however, that there is an evaluative message in all supervision.

Summative evaluation is described as the moment of truth when the supervisor communicates directly to the supervisee the supervisor's evaluation of the supervisee's performance relative to a set of criteria. Rather than providing continuing feedback, summative evaluation happens at a given point in time where a supervisee is informed of his performance. This type of evaluation happens more often in educational and training institutions rather than in field supervision (e.g., private practice).

Summative evaluation often causes enormous stress for both the supervisor and supervisee.

Criteria for evaluation

Establishing evaluation criteria is usually done within the context of one's profession and within the context of the relationship with the individual supervisee. The criteria pertain to knowledge, assessment and intervention skills, relationship characteristics, cultural awareness, and personal growth. Establishing criteria is particularly important for training and supervision that take place in institutions. Continued supervision of a supervisee who has entered the field is less formal and more collaborative.

Regarding evaluative criteria, Bernard and Goodyear (2014) mention that over the years, based on research, the criteria for the various professions have become more similar and standardized. They suggest that the criteria include:

> …theoretical grounding, diagnostic assessment skills, skills in establishing a therapeutic relationship with clients, skills in attending to individual and cultural characteristics in an appropriate and sensitive manner, skills in establishing appropriate goals, and intervention skills to help clients reach their goals. (p. 224)

It is important to identify the competencies that a supervisee is expected to acquire and to operationalize each. The latter is more difficult. It is also important to prioritize the competencies to be learned, that is to provide a time frame within which they are to be acquired.

Fouad et al. (2009) developed a list of 15 competencies that include seven core foundational competencies (i.e., Professionalism; Reflective Practice/Self-Assessment/Self-Care; Scientific Knowledge and Methods; Relationships; Individual and Cultural Diversity; Ethical Legal Standards and Policy; and Interdisciplinary System) and eight functional competencies (i.e., Assessment; Intervention; Consultation;

Research/Evaluation; Supervision; Teaching; Management; and Advocacy). The authors enumerated sub-competencies for each competency and indicated how each should be understood at the time that the supervisee is ready for practicum, internships, and entry to practice.

Favourable conditions for evaluation

Because of the vulnerability accompanying an evaluation, it is important for the supervisor to create as favourable conditions as possible when providing an evaluation of a supervisee. It might be very difficult for a supervisee to draw a boundary between their worth as a person and their performance as a helping professional. Favourable conditions make evaluation more palatable and influence the outcome of supervision. Ekstein and Wallerstein (1972) note that when the context of supervision is favourable, the supervisee stops asking "How can I avoid being criticized?" and begins to ask "How can I make the most of our supervision time?"

Drawing on the writings of authors who addressed, directly or indirectly, the favourable conditions for evaluation, Bernard and Goodyear (2014) provide a list of favourable conditions for providing evaluations.

1. Supervisors must be cognizant that supervision is an unequal relationship. Being sensitive of the supervisee's position helps the supervisor to be compassionate.
2. It is important for the supervisors to clearly state their administrative and clinical roles. This is particularly true for training institutions where it is necessary for the supervisor to inform the supervisee about whether she is involved in decisions that involve the supervisee's continued training.
3. The supervisor should address the supervisee's defensiveness openly and directly but in a compassionate and understanding manner. It is helpful for the supervisor at the beginning of supervision to teach supervisees how to receive corrective feedback.
4. Individual differences, such as gender, race, and cultural background, should be addressed openly. Competence in therapy includes the ability

to communicate in ways that are culturally flexible.

5. The process of evaluation should be mutual and continuous; that is, the supervisee should be involved in determining what is to be learned.
6. Evaluation should take place within a strong administrative structure. It is important for the supervisor to have the support of the institution and to know that his evaluation will be taken seriously. It is also important to inform the supervisee of the procedures to appeal an evaluation if she feels that it is unfair. In order to render fairness to the performance of a supervisee, it is suggested that she have more than one supervisor.
7. The supervisor should avoid a premature evaluation of the supervisee. The supervisor should avoid overreacting to a supervisee who shows great potential or to a supervisee that is faltering. This is not to say that the supervisor should withhold feedback or be dishonest. The supervisor is not to have favourites.
8. The supervisors must show their engagement in their own professional development to the supervisee. This can be accomplished by inviting the supervisee to provide feedback and for the supervisor to use it. Another way to demonstrate this engagement is for the supervisor to present ideas that they have recently been exposed to. The supervisor must remember that they are dealing with ideas and concepts, and not with facts.
9. Supervisors must keep an eye on the supervisory relationship as this influences all aspects of supervision. The supervisor must monitor the relationship so as to keep it from getting too close or too distant. Effective supervision takes place when the boundary between being too close and too distant is balanced. It is important for the supervisor to maintain a positive and supportive relationship with the supervisee: one that is professional and not personal.
10. A person who does not enjoy supervising should not do it.

The evaluation process

The evaluation process comprises the establishment of criteria and the choice of an instrument to communicate to the supervisee an assessment of her competency. The evaluative process describes how the supervisor will conduct supervision between the establishment of criteria and the evaluation provided to the supervisee and how evaluation is incorporated throughout supervision. In this sense, the evaluation process is embedded within the clinical supervision process. The evaluation process can be viewed in terms of six elements that interact throughout supervision. The six elements are: (1) establishing a supervision-evaluation contract; (2) choosing evaluation methods and supervision interventions; (3) selecting evaluation instruments; (4) providing formative feedback; (5) encouraging self-assessment; and (6) carrying out summative evaluation sessions (Bernard & Goodyear, 2014).

Establishing a supervision-evaluation contract

If supervision is offered within a training program, the supervisee should be provided with a plan that parallels a course syllabus. The syllabus should specify the supervision requirements, its objectives, and method of evaluation. In the case of supervision, however, the supervision contract should include individualized components; that is, it should include supervisee-initiated goals, referred to as goal-directed supervision which sets the stage for collaborative supervision (Talen & Schindler, 1993). Ample time should be taken to discuss supervisor's and supervisee's goals and these should take into account the developmental level of the supervisee. A clearly formulated supervision contract adds a sense of direction and security for both the supervisor and supervisee and adds to their satisfaction of their collaborative efforts. This topic is discussed again in chapter six.

Choosing supervision methods (collecting data) for evaluation

It is imperative that there be a discussion between supervisor and supervisee regarding the methods that will be used to gather the data for the evaluation process. The methods might include the supervisee's written

reports (e.g., intake and case reports), use of audio and video recordings, reports from other supervisors, and live supervision. It should be noted that the supervision methods chosen have both instructional and evaluative consequences. The supervisor might favour one method of gathering supervision data and this method might not paint the whole picture. Thus, it is important to have multiple methods of gathering data as this will lead to a more accurate picture of the supervisee's strengths and limitations.

Major areas of evaluation

The two major areas of evaluation are the supervisee's competency and client outcomes, or client welfare.

Competency: To assess for supervisee competency, the supervisor could do a systematic sampling of the supervisee's in-session performance and/or review audio and videotapes of the sessions. This sampling should include an evaluation of the supervisee's performance across clients and across stages of therapy (Martin, Garske, & Davis, 2000). Robiner et al. (1993) describe clinical competency as a "moving target with an elusive criterion" (p. 5). Although research challenges "the assumption that particular types of therapist knowledge, skill, or level of experience determine client outcome," there is evidence that "there are specific knowledge and skill sets that professionals must possess" (Bernard & Goodyear, 2014, pp. 222-223). Clinical supervisors therefore are responsible for monitoring the supervisee's development of knowledge, skill, and professionalism.

Client outcome: To evaluate client outcome, O'Donovan et al. (2011) state that "systematic assessment of client outcomes is essential to protect clients, to provide supervisees with data-based feedback on therapy progress, and to develop supervisees' skills in evidence-based practice" (p. 107). To benefit from therapy, the assessment of client outcome must be performed regularly across the course of the therapy with particular attention to identifying early failures. It is known that if clients do not improve in the first few therapy sessions, then there is a low probability of positive outcome (Harmon et al., 2007). Systematic assessment of clients

allows for early identification of clients who are not improving and thereby alerts the therapist to take action which enhances therapy outcome. To gather the data, one can use some form of outcome measure such as the Outcome Questionnaire 45 (OQ-45) (Lambert, 2010).

Client outcome may also be assessed informally, particularly in the cases of long-term therapy and where the psychotherapist is keenly attuned to the feelings, needs, and thoughts of the clients as they relate to the client's current struggles and challenges. In this regard, the psychotherapist is attuned to spontaneous feedback from the client. In addition, the psychotherapist may use part of every fifth session, for example, to review with the client progress that has been made and work yet to be done. For this type of assessment, it is imperative that the psychotherapist understand the client's inner world and how it impacts on his outer world such as interpersonal relationships, educational endeavours, and occupational satisfaction and success.

Selecting evaluation instruments

It is imperative that the supervisor and supervisee determine the instrument that will be used for the evaluation. There is no uniform instrument for this purpose and most instruments used are designed for a particular program or institution. The instrument to be used must determine, for example, the knowledge that is expected, the intervention skills, attitudes, and openness to feedback. Most evaluation instruments use a Likert scale. When such an instrument is used, it is important to indicate what is required to succeed in supervision (e.g., a score of 3 on a 5-point Likert scale). The scores need to have values assigned to them as well, such as: does not meet the criteria, meets the criteria, exceeds the criteria.

As an alternative to Likert scales, one can use what is referred to as *anchored rubrics* (Hatcher & Lassiter, 2007). Rubrics can be generic in the sense that they can be used to evaluate all competencies. The rubric can be formulated in terms of levels. Thus, for example, Level 1 indicates that the supervisee is performing inadequately on the skill set; Level 3 indicates that

the supervisee is performing adequately but somewhat self-consciously; and Level 5 indicates that the supervisee demonstrates mastery of the skill set (Bernard & Goodyear, 2014).

Another kind of rubric is one that "deconstructs a particular skill or skill set and attempts to describe more explicitly where the supervisee is performing along a continuum" (Bernard & Goodyear, 2014, p. 231). The rubric can be described in terms of Unacceptable, Acceptable, and Exemplary. For each category there is a list of behaviours that describe it. The authors provide a way that this can be done for the competency of "Participates in the supervisory process" (p. 232).

Example: For the competency of "Participates in the Supervisor Process," the corresponding behaviours for the three levels of performance might be:

Unacceptable: "Is not forthcoming in supervision" and "does not plan for supervision sessions."

Acceptable: "Comes to supervision with recordings of counselling sessions" and "Is prepared to ask questions of supervisor about his counselling."

Exemplar: "Comes to supervision with recordings cued at a particularly fruitful place for discussion" and "Is prepared to share outcome of using agreed-on supervision suggestions, and can reflect about success or lack of success" (p. 232).

When using this method, a clear description of acceptable and unacceptable behaviour for advancement might be helpful to a struggling supervisee. Since developing such a rubric is very time-consuming, it is suggested that it be used at times when a supervisee is struggling with a particular competency.

Providing formative evaluation

The core of supervision and of evaluation is providing the supervisee with feedback (Hahn & Molnar, 1991). The feedback should be given in an ongoing manner and supervisees should be given the opportunity to address

problems or deficits as they arise. The feedback to the supervisee should include feedback regarding the supervisee's work with clients, feedback regarding the supervisee's personal characteristics, and feedback regarding difficulties in the supervisory relationship. Supervisors also need to learn how to provide feedback to supervisees with low levels of openness to feedback (O'Donovan et al., 2011).

Based on their review of the research and clinical literature, Bernard and Goodyear (2014) provide a list of suggestions regarding communicating formative feedback. They state that feedback should:

1. Be based on learning goals (competencies) negotiated between supervisor and supervisee.
2. Be offered regularly and, as much as possible, based on samples of supervisees' work.
3. Be balanced between support/reinforcement and challenge/criticism.
4. Be timely, specific, and nonjudgmental, and offer direction for how to improve.
5. Address learning goals that the supervisee can achieve.
6. Use listening skills to conclude if feedback was received as intended.
7. Be owned by the supervisor as professional perception, not fact or truth.
8. Be a two-way street; that is, supervisor should seek feedback concerning their approach to supervision.
9. Be direct and clear, but never biased, hurtful, threatening, or humiliating.
10. Allow the supervisor to realize that supervisees want honest feedback and yet are fearful of it.
11. Enhance supervisees' trust that formative feedback has a different purpose than summative feedback.

Carrying out summative evaluation

Summative evaluations refer to a final evaluation but this does not imply a one-time or a single evaluation. In training institutions and externships, there are usually two summative evaluations: one halfway through the training and the second at the end of the training or externship. It is important that at the mid-term summative evaluation, the supervisee be informed of areas that require improvement with suggestions for improvement. Summative evaluations should be conducted face to face and always put in writing with an opportunity for the supervisee to add a note to the supervisor's written form.

Encouraging self-assessment

Assisting supervisees to evaluate their own professional practice is an important aspect of supervision (O'Donovan et al., 2011). Supervisors help supervisees in self-evaluation by reflecting on their own practice. The supervisees' commitment to self-reflect is a skill that is characteristic of efficient therapists across their professional career.

Although the idea of supervisee self-assessment is generally endorsed by the professional literature, the research results are mixed. The research has studied topics such as whether supervisees are accurate self-evaluators, the influence of the supervisors on the development of the supervisees' self-assessment, the supervisor's performance feedback on supervisee self-efficacy and anxiety, and whether self-critique leads to more supervisee openness to supervisor critical feedback. Based on the research, Bernard and Goodyear (2014) offer the following guidelines regarding the practice of supervisee self-assessment: (1) self-assessment is best viewed as a developmental issue for supervisees rather than a parallel process of supervision. Given this, it is recommended that self-assessment be made a goal of supervision and not used as an activity for evaluation; (2) the supervisor should regularly share how he arrives at assessment of the supervisee. For example, it is one thing to say, "You're not attending to the client's affect" and it is another thing to say "When I am assessing a session, I listen for important affect and whether the counsellor picks up on

it;" (3) self-assessment should be considered developmentally, not as a test, and monitored as a series of approximations toward a goal; and (4) at a summative evaluation, "evaluate self-assessment as a skill set rather than asking the supervisee to prepare an alternative self-evaluation" (p. 237).

Summary

A significant aspect of clinical supervision is the evaluation of the supervisee in terms of his assessment and conceptual skills, ability to plan and carry out interventions, knowledge of ethical and legal issues, and interpersonal skills. The evaluation process includes both formative and summative evaluations. It is imperative that the supervisee and supervisor establish the areas in which the supervisee is to be evaluated and the instruments used to perform the evaluation. It is important that evaluation be carried out in a constructive, collaborative, and supportive atmosphere. The supervisee is to be given an opportunity to provide feedback to his evaluation.

The next chapter presents the theoretical and practical aspects of providing clinical supervision. Included in the theoretical aspects is a thumbnail sketch of Self-in-Relationship Psychotherapy and the Four-Dimensional Model of Supervision. The practical aspects include the supervisor-supervisee contract and their respective tasks.

PART TWO

The Practice of Clinical Supervision

CHAPTER 6
Getting Started

This chapter serves as an introduction to chapter seven which presents and demonstrates a unique approach to supervision that integrates a therapeutic approach with a model of supervision. More specifically, it demonstrates how supervision is guided by Self-in-Relationship Psychotherapy and the Four-Dimensional Model of Supervision. The material from the previous chapters, such as the legal and ethical foundations of supervision, the methods and techniques of supervision, and the evaluation process, are interwoven in the demonstration.

The purpose of this chapter is to introduce the reader to the core constructs of Self-in-Relationship Psychotherapy (SIRP) and to the Four-Dimensional (4-D) Model of Supervision. It presents a sketch of SIRP and the components of the 4-D Model of Supervision. The SIRP approach and 4-D Model of Supervision provide the framework for the three demonstrations in chapter seven. Clinical supervision entails both a theory of psychotherapy and a model of supervision, very much like teaching involves both the knowledge of a discipline (e.g., biology) and a method of teaching. Theory and method are inseparable. This chapter also presents practical topics that need to be addressed before the commencement of supervision such as the supervisor-supervisee contract, the role of supervisor and supervisee, and evaluation procedures. This chapter is organized around two major topics, namely theoretical aspects of supervision and practical aspects of supervision.

Before proceeding to present the SIRP approach, it should be pointed out that the supervisor and supervisee can replace the SIRP approach by their preferred theoretical orientation and its constructs that guide their clinical

practice. It is assumed that one's psychotherapy approach guides the supervision process. In this sense, supervision is not divorced from theory.

Theoretical aspects of supervision

The theoretical aspects of supervision include a brief presentation of the SIRP approach and the 4-D Model of Supervision. More detailed information about the SIRP approach is presented in Meier and Boivin (2011) and Meier and Boivin (in press).

Self-in-Relationship Psychotherapy

Self-in-Relationship Psychotherapy is an integrated approach that includes both explanatory constructs and interventions (mechanisms) of change. The SIRP approach integrates explanatory constructs from psychodynamic-oriented therapies such as psychoanalysis, ego psychology, object relations theory, and self psychology, and interventions from action-oriented therapies such as person-centred therapy, Gestalt therapy, behavioural therapy, and cognitive-behavioural therapy.

SIRP pays attention to a client's inner world (i.e., subjective) and to a client's outer world (i.e., objective). As such, SIRP pays attention to a client's internal states (e.g., anxiety, depression); representations (e.g., parents); internal constructions (e.g., psychic organization); and coping strategies. SIRP also pays attention to a client's outer world, or to observable behaviours and interactions with others. SIRP assumes that behaviours and interactions with others are externally triggered and internally guided and have their roots in unsatisfactory infancy and early childhood relational experiences. It views emotional problems in terms of relational and self issues and concerns.

The SIRP approach is grounded on psychodynamic, self, and relational thought. A core thought is that unmet needs lie at the root of emotional problems. Two other thoughts are that therapeutic change progresses according to overlapping phases and that therapy moves forward when the issues' — referred to as themes — underlying symptoms are addressed and

resolved. This chapter limits itself to presenting six core SIRP constructs, namely self, relational, and physical intimacy needs; psychic organization; relational patterns; thematic approach to therapy; phases of the change process; and therapeutic interventions.

Self, relational, and physical intimacy needs

The notion of core needs is a foundational concept of SIRP in the same way that thoughts and feelings are core concepts of cognitive and experiential-oriented therapies, respectively. SIRP groups needs according to relational, self, and physical intimacy needs. This grouping of needs is based in part on the writings of Epstein and Baucon (2002); Deci and Ryan (2000); Reeves (2015); Mahler, Pine, and Bergman (1975); and Kohut (1977); and on the writers' clinical work with children, adolescents, and adults and on their research.

The authors arrived at the significance of human needs from their clinical work with children, adolescents, and adults. They observed that children crave the love and affection of their parents and want to be included with their peers. They observed that teenagers want to have a voice in matters that relate to their life; they want the freedom and autonomy to choose and make decisions. They observed in adults, particularly in couples, how one partner wants to spend more time with their partner and their partner wants more time for him/herself. It was also observed that when the needs go unmet for an extended period, individuals feel frustrated, and they become anxious, angry, and depressed. These observations led to the formulation of a psychotherapy approach that gives priority to human needs. To the two groups of relational and self needs, the authors added physical intimacy needs which include the need for sensual contact (i.e., touch, to be held) and sexual physical intimacy needs.

The core relational needs comprise the need for "emotional connection" (safe-anchorage) with a significant caregiver and the need to psychologically separate from the caregiver, to individuate, and to become autonomous and independent (Mahler et al., 1975). These two relational

needs are referred to as the "need for emotional connection" and the "need for autonomy." The need for emotional connection refers to the need for a mutual emotional and psychological closeness that is characterized by affection and trust between people. The need for autonomy refers to the need to psychologically separate from a person, that is to experience oneself as different from the other. It refers to being the origin of one's own behaviours (Deci & Ryan, 2002); to develop one's own interests, values, and goals in life; and to have the freedom to make choices and decisions. In terms of relationships, this need is often expressed in terms of wanting one's psychological space and the freedom to be one's own person and to make autonomous decisions and choices.

The need for emotional connection and the need for autonomy varies according to age and the developmental stage achieved (Mahler et al., 1975). When the need for emotional connection and the need for autonomy are not fully met in infancy/childhood, they will continue to push for satiation in adolescence and adulthood and, if not satisfied, may result in relational and self dysfunctions.

The core self needs include the experience of "being competent" and the experience of "being lovable/significant." These self needs are referred to as the "need for competency" and the "need for lovability" (Meier & Boivin, 2011, p. 155). Whereas the relational needs are about being connected to others and being one's own person in the presence of others, the self needs are about the subjective experience that one has of oneself, that is a sense of being competent and a sense of being lovable. The need for competency refers to the need to experience oneself as effective in one's ongoing interactions with others (relational competency) and to experience opportunities to exercise and express one's capacities (self-competency in relation to oneself). The need for lovability refers to the need to experience oneself as lovable, significant, worthwhile, and likeable, and as being a good person and attractive in relation to others.

Physical intimacy needs include both the need for "sensual contact" (i.e., touch, to be held) and the "need for sexual physical intimacy." The "need for sensual contact" refers to the need for physical contact (e.g., touch, hugs, to be held) and/or physical presence (e.g., to be in the same physical space) but not with the intent of sexual expression. The "need for sexual physical intimacy" refers to the need for physical contact with the intention of a sexual expression. This includes hugging, kissing, and fondling that find their mutual satisfaction and completion in genital expression.

In summary, the relational, self, and physical intimacy needs play out together and impact one other. The manner in which caregivers acknowledge and affirm them and how they are realized and integrated affects all aspects of the personality. When these needs go unmet, problems, as indicated above, are apt to occur. However, it is important to remember that unmet needs do not inevitably lead to emotional problems. One cannot make predictions about the outcome when needs go unmet; one can only trace a problem back to its roots.

Psychic organization

As mentioned earlier, SIRP addresses the whole person which includes both her inner world and her interactions with the outer world. The inner world comprises cognitive, affective, memory, sensory, and motivational aspects. The interactions with the outer world include behaviours, relationships, communication style, and interpersonal patterns.

The person's interactions with others, particularly in the early years of life and during adolescence, are very formative in the building of the inner world. The SIRP approach holds that a person begins life with innate biological, social, and psychological capacities, and/or potentials necessary to live a wholesome life. It also holds that the person is born into an external physical, social, and relational world that has expectations, values, and ideals to acquire and internalize in order to live harmoniously with others. Over a period of time, the person makes her own social and relational expectations, values, and ideals. Thus, a person's inner world is

constituted by the innate biological, social, and psychological givens and/or potentials on one hand and the social and relational expectations, values, and ideals on the other hand. Hence, we can speak of two internal forces: the innate and the acquired. The person is also born with the capacity to reconcile these two forces and to achieve ever-expanding levels of integration. This capacity can be thought of as a third force. Under ordinary conditions, the innate forces are dominant as they are biologically and psychologically rooted in a person's very being whereas the social and relational forces are acquired and become, together with the third force, shapers and moderators of the innate forces' influence in terms of the manner in which the innate givens will be actualized in a person's social and relational interactions and influence the development of a sense of self.

The inner world, therefore, constitutes three forces: the innate, the acquired, and the capacity to moderate and creatively give direction as to how the two forces are played out in real life. Theorists who subscribe to the existence of an inner world have given these three forces (innate, acquired, capacity to reconcile and give direction) various names. Respectively, Freud (1923) named the three forces the id, the superego, and the ego; Fairbairn (1944) referred to them as the libidinal, the antilibidinal, and the central ego states; and Berne (1976) called them the child, the parent, and the adult. Collectively the three forces have also been referred as internal representations (Klein, 1961), psychic organization (Freud, 1923), ego states (Watkins & Watkins, 1997; Lawrence, 1999), schemas (Young, 2005), and model scenes (De Young, 2003). The three internal forces collectively form dynamic and organized but mutative cognitive-affective-motivational systems (CAMS) that give direction to a person's actions and behaviours; the development of attitudes, values, and ideals; and how a person deals with the tasks and challenges of daily living. The CAMS constitute the substratum for the development of an individual's character and personality.

The SIRP approach views the three forces as forming the psychic organization. None of the classification systems of the three forces (e.g.,

Freud, Fairbairn, Berne) is adequate in and by itself. Each provides a view of the inner world very much like a person has a different view of a castle when seen from the north, south, east, and west sides. SIRP adopts and integrates the Freudian classification system which presents a biopsychological perspective with the Fairbairn view which presents a psychological perspective. Freud's id, superego, and ego form the foundation into which is integrated Fairbairn's system. The psychic organization, therefore, is as follows: the id comprises the innate (i.e., needs) and the repressed (i.e., oral libidinal id); the superego comprises the ideals and values to live by (i.e., ego ideal) and the prohibitions (i.e., conscience); and the ego comprises the creative potentials (i.e., central ego state) and the defences.

Although the formation of a person's psychic organization has its beginning in the early years of life, its formation is never complete but continues to change throughout life. A good example is the effect that the experience of trauma has on a person's psychic organization (i.e., her inner world) and forever changes it. A person's psychic organization constantly interacts with the outer world and at one time influences her pattern of relating, style of communicating, and thoughts and feelings about self, and at another time is influenced by the contacts with the outer world and brings about changes to her psychic organization. The person's inner and outer worlds are in constant interaction and mutual change.

Relational patterns

In addition to paying attention to a client's subjective experiences, the SIRP approach pays equal attention to the client's external behaviours such as the style of communication and relational patterns. A relational pattern refers to the manner in which an individual interacts with another person such as being submissive, domineering, empathic, and collaborative.

In the course of satisfying her core relational, self, and physical intimacy needs, the infant/child forms and internalizes a pattern of relating to others that is formed in large part by the nature and quality of the interactions of

the caregiver in helping the infant/child meet her relational, self, and physical intimacy needs. The acquired relational patterns serve as a prototype for the infant/child's future relationships and shape the expectations about the way in which relational and self needs are to be met.

When the infant/child is exposed to an environment that is not good enough, she might acquire relational skills that are helpful at that age but become problematic in adolescence and adulthood. That is, the child and pre-teen might acquire repetitive, compulsive, and ineffective relational patterns that are driven by unmet underlying needs and which have as their purpose to establish and maintain relationships and to control (e.g., orchestrate) the nature of these relationships. The manner in which the individuals perceive themselves (e.g., helpless, unlovable) and how they perceive others (e.g., powerful, lovable) influences the nature and quality of their relationship. These repetitive and compulsive interpersonal patterns have been given the names of "maladaptive cyclical patterns" (Strupp & Binder, 1985; Levenson & Strupp, 2007) and "projective identifications" (Klein, 1959; Cashdan, 1988).

The person's relational, self, and physical intimacy needs propel her to develop meaningful relations, and these needs together with the responses from others influence the quality and nature of the individual's manner of relating. The earliest of the child's patterns of relating to others are needs-based; that is, others are related to as they satisfy the basic needs of the infant/child. As the infant/child becomes a teenager and adult, she is more able to relate to others in a mutually responsive way to the needs of self and of others.

Transferences and countertransferences and parallel processing and isomorphism, as described in the second chapter, are variants of interpersonal patterns. As such, they too are propelled either by unmet childhood needs or by mature adult needs. A SIRP-oriented psychotherapist pays careful attention to a person's relational pattern to determine how it reflects unmet childhood needs or unmet mature adult needs. The goal is for

the person to identify the unmet need and learn how to assert this need in meaningful ways in her interactions with others.

Thematic approach to psychotherapy

The SIRP model takes the position that one does not directly treat diagnostic disorders such as major depressive disorders, obsessive-compulsive disorders, and panic disorders (Meier, Boivin, & Meier, 2006). Rather, one treats the constituents of the diagnosed disorder. For example, the constituents of depression include a sense of hopelessness, feeling helpless, being harsh towards oneself, feeling worthless, and being prone to feelings of guilt or shame. Thus, it is important not to be blinded by a diagnosis, but rather to be attentive to various issues associated with a disorder that the client is struggling with. The various issues or constituents associated with a disorder are referred to as themes. Meier and Boivin (2000) define a theme as comprising "the personal or interpersonal difficulties, concerns, and/or problems and troubling thoughts, disturbing emotions, and experiences of loss explicitly or implicitly raised and/or worked on by the client within the course of psychotherapy" (p. 59).

In their research on the progression of psychotherapy, Meier and Boivin (2000) and Meier, Boivin, and Meier (2006; 2008; 2010) identified descriptive, second-order, and core themes. Therapy moved forward when the therapist and client addressed second-order themes, and therapy came to a successful conclusion when the core theme was indirectly worked through. The core theme in the case of the client diagnosed with major depressive disorder was not living life in an authentic way to himself and to others; that is, he lived life according to the expectations of others rather than from his own sense of selfhood (Meier et al., 2006).

Phases of the change process

A tenet of the SIRP approach is that psychotherapy is a process that evolves across time and space according to overlapping phases or stages. Psychotherapists of the past viewed psychotherapy, particularly long-term

psychotherapy, as a process that moves forward through overlapping stages or phases (Bluger, Doughty, Gingrich, Hare, & Melanson, 1984). However, the theoretical orientations differ in describing the phases. Psychodynamic and experiential-oriented approaches viewed the change process in terms of exploration, awareness, and consolidation phases whereas the action-oriented therapies viewed the change process in terms of problem definition, commitment, and action phases.

It is only recently that psychotherapy researchers began to pay attention to the stages or phases of the change process and to formulate models of the change process. Notable among these models are the Transtheoretical Model (Prochaska & Di Clementi, 1983), the Assimilation Model (Stiles, Morrison, & Haw, 1987), and the Seven-Phase Model of the Change Process (SPM) (Meier & Boivin, 1983, 1992, 1998).

The SPM comprises seven overlapping phases, namely Problem Definition, Exploration, Awareness/Insight, Commitment, Experimentation/Action, Integration/Consolidation, and Termination (Meier & Boivin, 1998). The SPM model has been empirically tested in two different ways. First, the transcribed therapy sessions of one client (for example 18 sessions) were analyzed using the model. Research demonstrated that the seven phases accounted for nearly 100% of the clinical material of the transcribed interviews. Second, the model was applied to the transcripts of a client's combined therapy sessions (for example 24 sessions). The therapy sessions were segmented into meaning units called themes. The researchers identified the themes (e.g., sense of helplessness, inauthenticity) and traced how they were worked through across the session using SPM as a measure. It was observed that in successful therapy outcome there was a forward movement through the phases beginning with problem definition, followed by exploration and awareness, and terminating with action and consolidation (Meier & Boivin, 2000; Meier, Boivin, & Meier, 2006, 2010). It was observed, as well, that a client began by focusing on one theme, worked it through the seven phases, and then would return again and again to work through other themes. This

would proceed until the core theme, such as being inauthentic with self and others, was worked through and the client strove to be authentic in all aspects of her life.

Viewing the process of psychotherapy in terms of phases and/or stages provides a map that indicates where a client is at in addressing a concern or an issue. Clients may differ in terms of where they are at on the phase continuum when they begin therapy. A client who has given much thought to her concern or issue, for example, might have an awareness of the problem but not know how to translate the awareness into action. Another client might have minimal understanding of her problem; for this client, it would be important to do exploratory work and gain awareness/insight before engaging in the development of new behaviour.

A SIRP-oriented psychotherapist is attentive to where the client is at with reference to the phase of the psychotherapy process and focuses therapy on that phase. To help a client move from problem definition phase to awareness phase requires the setting of goals and use of techniques that are different than helping a client move from awareness/insight phase to experimentation/action. In the former, the goal is to help the client gain greater awareness/insight by the use of an exploratory technique such as experiential focusing (Gendlin, 1996), whereas in the latter, the goal is for the client to begin to live according to her new awareness/insight which can be facilitated by the use of assertiveness training (Wolpe, 1990) or engaging in an imagery exercise (Meier & Boivin, 2011). It is important for the therapist to be attentive to a client's forward movement through the phases and adapt to the client's progression through the phases.

Therapeutic interventions

Therapeutic techniques and interventions are used with a specific goal in mind. For example, to help a person who is out of touch with her feelings, one might use the experiential focusing technique (Gendlin, 1981, 1996); for a person who is engaged in internal dialogue and is disturbed and conflicted by this dialogue, one might use the Gestalt two chair technique

(Perls, 1969); to help someone see the connection between current feelings or behaviour and childhood experiences, one might use ego state therapy (Lawrence, 1999); to help someone transform internal processes and develop new perceptions and behaviours, one may choose Task-directed Imagery (Meier & Boivin, 2011) and cognitive restructuring (Beck, 1976; Leahy, 2006); and to undo old behaviours and develop new ones, one might use behavioural rehearsal and assertiveness training (Wolpe, 1990). The SIRP approach makes use of all of these techniques. However, their use is guided by SIRP constructs and not by the theory from which they originate. The use of the technique for its own sake is less meaningful; a technique is meaningful when it is used to achieve a theoretically determined goal.

Clients typically seek professional help to deal with troubled emotions, behavioural problems, and/or relational issues. Depending on her orientation, a psychotherapist will address the behaviour, the emotion, and/or her thinking process and cognitive structure. A behavioural therapist is interested in the troubling behaviour and would use techniques such as reinforcement, assertiveness training, and regulation of affect to diminish the troubling behaviour and develop new behaviours. An experiential-oriented therapist would focus on the emotion/feeling with the goal of having the client release pent-up feelings by verbalizing/outwardly expressing them. A cognitive-oriented therapist is interested in the client's thoughts or processes that underlie the emotional or behavioural concerns and works towards cognitive restructuring.

The Four-Dimensional Model of Clinical Supervision

The Four-Dimensional Model of Clinical Supervision (4-D Model of Clinical Supervision) embraces and integrates aspects from the models presented in the second chapter. The four dimensions are: developmental, social role, competency, and therapy process.

The first dimension, developmental dimension, considers the developmental stage of the supervisee as a therapist, that is whether she is at the beginning, intermediate, or advanced stage of development. The

assumption is that growth is ongoing and learning is a lifelong process. Each level is characterized by specific needs and tasks. As well, each level has three trends, namely self-and-other awareness, motivation, and autonomy. The supervisor also pays attention to the supervisee's relational and emotional capacities. It is possible that a supervisee could be considered to be at the intermediate or advanced level in terms of conceptual and interventions and at the same time not have the relational and emotional capacities to support the higher levels of development. It is anticipated that by maintaining regular quality clinical supervision sessions with qualified supervisors, supervisees will: (1) experience growth in self-awareness, skill, and knowledge; (2) be aware of and trained in best practices in their respective areas of service; (3) be evaluated regularly and given feedback on professional competency; (4) be more aware of ethical and legal requirements; (5) experience greater work satisfaction, health, and employment longevity; and (6) provide more effective, high quality service to clients.

The second dimension, social role dimension, includes the role that the supervisor assumes in the supervisory relationship. This may include teacher, consultant, mentor, or supervisor. With beginning supervisees, the supervisor might more frequently assume the role of a teacher and counsellor whereas for a supervisee at the advanced level, the supervisor might assume the role of mentor and consultant.

The competency dimension comprises the skills and competencies that are required of the supervisee in order to provide effective therapy to clients. Included among these are knowledge of various theoretical orientations, ability to conceptualize client concerns, capacity to plan treatment and carry it out, safe and effective use of self, legal and ethical foundations of therapeutic practice, and ability to manage transferences and countertransferences. It is essential that the practice of therapy be guided by sound theory and knowledge from practice-based therapy.

The fourth dimension, therapy process dimension, relates to the process of supervision, that is whether supervision focuses on the client, on the client and therapist relationship, or on the supervisee and supervisor relationship. With beginning supervisees, the focus more often is on the client, whereas with advanced supervisees, the focus also includes the client and therapist relationship and the supervisee and supervisor relationship.

The 4-D Model of Clinical Supervision, or part of it, can be used by a supervisor of any theoretical stripe. The supervisors would differ in terms of the competency dimension particularly as it relates to the application of concepts from a specific theory and the ensuing treatment which follows from that theory. The four dimensions of the 4-D Model of Supervision are illustrated in the following chapter. The illustrations are organized according to whether the focus of the supervision is the client, the client and therapist, or the therapist and supervisor.

Practical aspects of supervision

Some of the practical aspects of supervision to be discussed before the beginning of a supervision arrangement include the supervisor-supervisee contract, the tasks of the supervisor and supervisee, and the evaluation procedures. A discussion of the general and specific tasks of the supervisor and supervisee and the evaluation procedures are part of the contract; however, for this chapter they are presented as separate topics.

Supervisor-supervisee contract

At the beginning of supervision, be it in an educational/institutional setting or as part of the supervisee's application to become certified with a regulatory body, it is recommended that the supervisor and supervisee negotiate a contract that details the nature, goals, tasks, and processes of supervision. The goals and tasks negotiated are to be based on the supervisee's learning needs, overall program-learning objectives, developmental stage of the supervisee, context-specific learning needs, and

the supervisor's evaluation of the supervisee's strengths and learning needs (O'Donovan, Halford, & Walters, 2011, p. 106).

It is important to verbally inform the supervisee that she will not be entitled to the same tenets of confidentiality as clients. The supervisee is to be informed that the supervisor has the responsibility to provide evaluative information to third parties as well as to the supervisee. The supervisor's responsibilities are to protect, in the following order, the client, the public, the profession, and the supervisee. However, the supervisor will only share information that relates to the supervisee's functioning and competency. To minimize negative reactions to such sharing, the supervisor makes sure that the supervisee is clear about the unique limitation of confidentiality in the supervision relationship, and that the supervisee knows the order of responsibility (as indicated above). In addition, the supervisor needs to provide honest and clear feedback to the supervisee, and the supervisor needs to discuss with the supervisee the information to be shared with outside sources (Sherry, 1991; Aasheim, 2012).

The contract should include: (1) the purpose of the supervision arrangement (e.g., for a training period or for a year of supervised practice); (2) the supervisor and supervisee's goals and expectations of supervision (e.g., professional development and/or monitoring client welfare); (3) the supervisor and supervisee's responsibilities; (4) scope of practice and competency (e.g., individual therapy or family therapy); (5) logistics (e.g., length, frequency, and location of meetings, fee for supervision services and method of payment, and billing practices); (6) monitoring supervision and methods of professional development (e.g., use of video and audio tapes and/or session records); (7) preparation expectations (e.g., present an intake report and/or case reports); (8) reporting and evaluation practices and schedules (e.g., frequency and method of evaluation); (9) informed consent (e.g., counsellor informs client that they are under supervision); (10) duly signed contract (e.g., include names, dates, signatures, and contact information) (Aasheim, 2012, pp. 64-67); and (11) the preparation and submission of reports to third party (e.g., lawyers, the court, and/or

insurance companies). The contract is to be in writing and signed by both parties.

A clearly formulated supervision contract adds a sense of direction and security for both the supervisor and supervisee and augments their satisfaction of their collaborative efforts. Establishing and agreeing to specific goals enhances self-reflection on the part of the supervisee, provides a clear agenda for supervision, increases the likelihood that supervision time will be focused and effective, and provides a template for evaluating supervision.

Contract: In training/educational institutions

If supervision is offered within a training program, the supervisee should be provided with a plan that parallels a course syllabus. The syllabus should specify the supervision requirements, its objectives, and method of evaluation. In the case of supervision, however, the supervision contract should include individualized components; that is, it should include supervisee-initiated goals, referred to as goal-directed supervision, which set the stage for collaborative supervision (Talen & Schindler, 1993). Ample time should be taken to discuss supervisor's and supervisee's goals, and these goals should take into account the developmental level of the supervisee. A model of a supervisor and supervisee contract in an educational institution is presented in Appendix B.

Contract: Applying for certification with a regulatory body

When the supervisor provides supervision to a supervisee who is applying for certification with a regulatory body and who is in private practice, the following items constitute the core of the contract. The supervisee: (1) provides documentation regarding training, education, experience (to determine areas of competency); (2) provides an annual copy of liability insurance; (3) adheres to a code of ethics; (4) participates in ongoing professional education activities; (5) provides adequate documentation (e.g., intake reports) to plan treatment; (6) informs clients

coming under this agreement that the practice is under the supervision of a supervisor and provides his/her name, status, and qualification; (7) notes on all public documents and webpages that the services are supervised by a supervisor; (8) ensures that all written reports requested by lawyers, insurance companies, and courts are counter-signed by the supervisor; (9) monitors progress of work through regular supervision (e.g., once every four to six weeks); (10) ensures that clients pay the therapist the agreed fee which is receipted by the supervisor; and (11) pays the supervisor the agreed fee. An example of a supervisor-supervisee contract is presented in Appendix C.

Tasks of supervisor and supervisee

It is imperative that the clinical supervisor, at the beginning of supervision, establishes a safe and private environment so that the supervisee can be candid and open about her professional experiences. It is equally important to clearly specify the tasks expected from the supervisor and supervisee and from the supervision process. The tasks of supervision can be thought of in terms of general tasks as well as specific and hands-on in-session supervision tasks.

General tasks

The Arizona Department of Health Services (2008, pp. 3-4) recommends regular supervision which is grounded in best practices. It lists the tasks that the supervisor should complete within the supervision process.

1. Explore and clarify the supervisee's critical thinking skills by giving them practice to conceptualize cases.
2. Encourage the development of the supervisee's intuitive skills by guiding them to look beyond words and objective materials.
3. Teach and supervise the proper and ethical use of assessment and diagnostic tools and procedures.
4. Maintain clear professional boundaries between supervisor and supervisee and teach proper boundaries between supervisees and

clients.

5. Provide clear, specific, objective feedback on the strengths and weaknesses of supervisee skills.
6. Discuss conflict with supervisees when it happens.
7. Respect human diversity and individual differences that may exist between the supervisor and supervisee and provide safe opportunities to discuss those differences.
8. When appropriate, share information, experience, and skills from their own professional practice.
9. Be aware of organizational and institutional policies and procedures which the supervisee must follow.
10. Maintain records of supervision which include the cases, skills, and concerns discussed.
11. Be aware of the different models of clinical supervision that reflect different professional training, expectations, and work contexts.

Specific and practical in-session supervision tasks

O'Donovan, Halford and Walters (2011) provide a list of practical in-session supervision tasks. This list has been expanded to include other tasks suggested by the current author.

1. Providing the content of the client's therapy session via an intake report.
2. Discussing the content of the report in terms of understanding the client (conceptualization), choice treatment, and use of interventions.
3. Reviewing audio-visual recordings.
4. Demonstrating or practicing specific therapy skills.
5. Discussing relationship of supervisee and client – how does the supervisee experience the client (dialectic of transference and countertransference)?

6. Discussing the supervisor's experience of the supervisee – parallel processing.
7. Ensuring that supervisees remain within their level of training and competency.
8. The supervisor being assured that the client is benefiting from therapy.
9. Discussing future therapeutic plans with specific clients.
10. Confronting personal and professional blocks to growth and self-awareness of supervisees including behaviours and conditions that may cause impairment.

Evaluation procedures

Supervisees should clearly know how they will be evaluated. The instrument used for evaluation should be noted in the supervision contract together with a clear statement about practicing within the scope of one's training and practice. It is important for the supervisor to clearly articulate how she will evaluate the supervisee's competence.

In an educational setting, an instrument for evaluation might be provided. When such an instrument is not provided, the supervisor must determine which instrument she will use for the evaluative process. The supervisor might use published tools such as the Counseling Skills Scale (Eriksen & McAulife, 2003) or the Skilled Counseling Scale (Urbani et al., 2002). In place of these, the supervisor might create her own scale in keeping with the orientation of the supervision. When developing an instrument for evaluation in an educational setting, it is imperative that it include the domains and evaluation criteria pertinent to the program. The domains might include interpersonal skills, assessment and conceptual skills, treatment interventions, knowledge of ethics and standards of practice, the effective and safe use of self in psychotherapy, and the application of theory to practice.

When the supervisee is an applicant for certification with a regulatory body or an association (e.g., CRPO), it is imperative that the supervisor and

supervisee are familiar with the requirements of the regulatory body and association. The supervisor's responsibility is lightened when evaluation procedures, criteria, and forms are available. The supervisor and supervisee review the areas of evaluation and the manner of evaluating performance on these areas.

When there are no explicit evaluative procedures available other than the requirement of a given number of hours of direct client contact and the number of hours of one-on-one and/or group supervision, the supervisor's task becomes more demanding and complex. Without guidance from the regulatory body, the supervisor and supervisee together are to determine the domains for evaluation. In determining the domains on which the psychotherapist is evaluated, the supervisor and psychotherapist are mindful of the requirements of the regulatory body, the level of training and academic formation, and the requirements of the psychotherapist's actual practice. In addition to this, the supervisor uses her knowledge and experience as a psychotherapist when determining areas for evaluation.

The domains on which the psychotherapist is evaluated might include interpersonal skills, assessment and conceptual skills, treatment interventions, knowledge of ethics and standards of practice, the effective and safe use of self in psychotherapy, and the application of theory to practice. The supervisor is not to evaluate a supervisee on skills not demanded by the regulatory body or association and profession. As an aid in supervision, the supervisor might create an evaluative form which includes the domains to be evaluated and the corresponding criteria to do so. An example of a supervisor-constructed appraisal form is presented in Appendix D.

Summary

This chapter presents the SIRP approach to assessment, conceptualization, and treatment and the 4-D Model of Supervision. The assumption is that since psychotherapy is guided by a theory and since the goal of clinical supervision is to enhance the skills of the supervisee,

supervision too is theory-based. The 4-D Model of Supervision accounts for the developmental, social role, competency, and therapy foci dimensions of supervision. The chapter also presents the practical issues that need to be addressed before beginning supervision. These include the supervisor-supervisee contract and the tasks to be performed by the supervisor and supervisee.

The following chapter describes three foci of supervision and demonstrates each by the use of a transcript of a role-played supervision session. The three foci are: client-focused, client-therapist-focused, and therapist-supervisor-focused supervision.

CHAPTER 7

The Process Model of Supervision in Practice

Hawkins and Shohet (1989, 2012) developed a double-matrix model of supervision which they called the Process Model of Supervision. The double-matrix model of supervision involves two interlocking systems or matrices: *the therapy system* that interconnects the therapist and the client through an agreed contract, shared task, and time spent together; and *the supervision system* that involves the therapist and the supervisor through their agreed contract, shared tasks, and time spent together. The supervisory task is to pay attention to the therapy, and depending on how this attention is given, different supervisory styles emerge (p. 56).

The Process Model of Supervision identifies two styles of supervision, namely Style I and Style II. In Style I, the supervisee and supervisor reflect on and review reports, written notes, or tape recordings of the therapy session. In Style II, supervision pays attention to the therapy matrix and how it is reflected in the here-and-now experience of the supervision process.

Each of these two major styles of supervision is further divided into three modes (categories) depending on the focus on the supervision process. The results are six modes of supervision that are summarized on Table 2.4. The three modes (categories) of supervision are: client-focused supervision, therapist-client-focused supervision, and supervisee-supervisor-focused supervision.

The purpose of this chapter is to present and demonstrate the three foci of the Process Model of Supervision. Each focus of supervision includes the

four dimensions as outlined in the Four-Dimensional Model of Supervision. That is, it entails the role that the supervisor assumes in a supervision session (e.g., teacher, therapist); the developmental level of the supervisee (e.g., beginner, intermediate, advanced); and the competency that is addressed (e.g., conceptualization, dealing with countertransference). The specific focus of the supervision defines the fourth dimension (e.g., client-focused; client-therapist-focused).

The process model pays particular attention to how both therapy and supervision unfold across time and space. That is the meaning of "process." However, this does not exclude the need for structure which is provided particularly by theory or an understanding of human motives and behaviours. Theory brings structure to the therapy and supervision processes.

The chapter begins with a presentation of the first focus of supervision. This involves obtaining appropriate clinical material via a semi-structured interview which provides the basis to conceptualize the client's problem and to plan appropriate treatment. The chapter then presents the second focus which addresses the therapist and client relationship, its development, and the concomitant experiences of transference and countertransference and how to manage them. The last part of the chapter presents the third focus which relates to the supervisee and supervisor relationship. The issues that arise during the course of supervision, such as parallel processing, are addressed.

Each of the three foci differs in terms of the role assumed by the supervisor, the tasks that are addressed, the supervisee's level of professional development, and the techniques used by the supervisor. For example, for the first focus, the supervisor might assume the role of a teacher to instruct the supervisee about a specific emotional disorder; for the second focus, the supervisor might assume the role of a counsellor to support the supervisee who cannot manage the client's transference; and for the third focus, the supervisor might assume the role of a consultant or

mentor and engage in a meaningful discussion regarding conceptualization and treatment.

After presenting one focus of supervision, the author demonstrates the focus by a transcript from a role-played supervision session. The client presented does not refer to any particular person but represents a combination of several. The transcribed sessions demonstrate how the three foci may appear concretely in actual practice.

Client-Focused Supervision

The first two modes of the process model focus on the client. Mode 1 focuses on the content of the therapy session and Mode 2 focuses on the treatment. The supervisor's and supervisee's activities, interactions, and relational issues are presented and discussed for the two modes (Table 2.4).

Mode 1. Reflection on the content of the therapy session

The supervisee's task of this mode is to present and accurately describe the clients. Included in this description are the clients' reason for therapy, their physical appearance, their behaviour during therapy, the tone of their voice, and their use of language (e.g., images and metaphors). The presentation of the clients also includes their life story, that is information about their family of origin, education, occupation, social life, romantic relationships, physical and mental health, hobbies, and philosophy of life. The focus is less on the content and more on the quality of relationships that clients have in various settings (i.e., interactions) and how they feel about themselves in these interactions (Hawkins & Shohet, 1989, p. 61).

It is very important for the supervisee, at this initial mode of supervision, to encounter the clients in the "fullness of their unique being" (Hawkins & Shohet, 1989, p. 60) before making assumptions about their presenting problems and before intervening. It is the task of the supervisor to challenge such assumptions and direct the supervisee to what they saw and heard. One needs to guard against fixed ideas about human conditions or a pet theory to explain emotional problems (e.g., diagnosis of bipolar when it might be

borderline personality disorder). On this matter, Shainberg (1983) emphasizes the importance of being with the client before doing, or before intervening. The author states:

> Focus all your attention on seeing as clearly as you can the way the person behaves and what you think and feel being with her. Do not try to find meanings, make connections, or understand. Observe what takes places and your responses. (p. 169)

It is obvious that as the supervisee is putting aside her own biases and assumptions and listening to the client in order to see her as a whole person, the supervisee is being guided by an implicit theory as to what to pay attention to. It is a natural part of being human to bring meaning to what one experiences and to what one experiences in the other.

Following the presentation of the client content, the supervisor and supervisee explore the connection of the content of one part of the session with another part of the session and also the connection to the content of previous sessions. The goal is to see the clients' content as a whole and form one picture of the client. Connections can also be made between client content and life outside of therapy and also prior to therapy.

After the client content has been presented and links have been established with previous content and life outside of and prior to therapy, there is place for the formulation of theory to understand the client, to form an assessment, to formulate a conceptualization of the problem, and to plan treatment. If appropriate, the theoretical model of the supervisee will lead this process.

Role of the supervisor:

The supervisor pays attention to what clients chose to talk about, how clients presented themselves, what they wanted to explore, and how the content of this session relates to the content of the last session. The goal of this form of supervision is to help the therapist pay attention to the client and sharpen their behavioural observation when working with the clients.

Another goal is to help the supervisee develop skills to conceptualize and to plan appropriate treatment.

Mode 2. Exploration of the strategies and interventions used by the therapist

The goal of this mode of supervision is to design a plan for treatment, to determine treatment interventions and to provide a rationale for both the treatment plan and the choice of interventions. Alternative strategies and interventions are considered and perhaps developed, and their consequences are anticipated. The main goal of this mode of supervision is to increase the therapist's choices and skills in intervention. Within this mode, supervision is primarily focused on the supervisor helping the supervisees to develop their specific skills in planning treatment and selecting appropriate interventions to achieve the goal. The focus is on the client. A supervisor, Davies (1987), who uses this mode as the focus of his supervision, asks the supervisee the following questions:

> I ask them what interventions they have made? What reasons they had for making them? Where their interventions were leading them? How they made their interventions and when? Then I ask what do you want to do with this client now? (cited in Hawkins & Shohet, 1989, p. 61)

It is important for the supervisee to possess a wide range of interventions such as experiential focusing, empathic responding, and task-directed imagery; as well, the supervisor needs to know when and how to use these interventions (Meier & Boivin, 2011). In addition to possessing these interventions, it is also important for the supervisee to be creative and able to design interventions to help a client move forward or for the client to experience something in a new way (e.g., being assertive with a supervisor).

Supervisees can get stuck in dualistic thinking and make statements that include an either/or way of thinking (e.g., either I confront the client's tardiness or put up with it). This thinking on the part of the supervisee is

based on seeing only two options. The task of the supervisor is to help the supervisee see that she is operating under a restrictive assumption and to help the supervisee generate new options for intervening. This can be done by using a brainstorming approach. The basic rules of brainstorming are: "(1) say whatever comes into your head; (2) get the ideas out. Don't evaluate or judge the ideas; (3) use the other person's ideas as springboards; and (4) include the wildest options you can invent" (Hawkins & Shohet, 1989, p. 61). Often the wildest options contain the germ for a creative way forward. While searching for other intervention options, a supervisee can experiment by using a technique such as the empty chair to engage in a monologue. When two or more supervisees are present, one can play the role of the client and the other the role of therapist in trying out an alternative technique to determine its appropriateness and potential effectiveness.

When considering using a technique, one has to consider whether the timing is appropriate, or where in the therapy session it is appropriate to use the technique. In deciding to use a technique, it is important to have a sense that the client is ready for it. Using a technique for which the client is not ready could constitute an ethical violation. Thus, it is always important to consider the ethics when using a technique (Meier & Boivin, 2011, p. 13).

Role of the supervisor:

1. From the point of view of developing competency and gaining autonomy, it is wise for the supervisor not to suggest or recommend specific intervention skills. Rather, the supervisor should help the supervisee to discover techniques that are helpful to the client and yet consistent with the supervisee's personality and style of therapy.

2. The supervisor will help the supervisee to assess whether she has the necessary training to ethically and effectively use a proposed intervention.

3. The supervisor will help the supervisee to move away from her pet way of doing therapy and consider other ways of going about it.

Illustration: Client-Focused supervision

Introductory Comment

The following is a transcript of a role-played supervision session with an intermediate level therapist, Jessica, and the author, Augustine. The supervision session demonstrates client-focused supervision. Although the supervisor could have chosen to have the supervisee talk about her feelings, he chose, for this session, to put the focus on the client.

The goal of client-focused supervision is to get to know the client's presenting problem, the precipitators of the problem, and any predisposing and maintaining factors. The supervisee obtains background information regarding the client's current relationships and her childhood and adolescent relationships with significant others. This information forms the basis for a conceptualization of her presenting concerns. In conceptualizing the problem, the supervisee draws constructs from her theoretical orientation. Following the conceptualization, the supervisee and supervisor discuss and decide on treatment goals, approach, and interventions.

Transcript of Supervision Session

Supervisor: Hi, Jessica.

Therapist: Hi, how are you, Augustine?

Supervisor: Not too bad. How are things going in your practice?

Therapist: Okay, but I definitely need to talk to you about one of my clients. I just want to feel that I am going in the right direction.

Supervisor: Mhm.

Therapist: I've seen her for about five sessions. She's a 42-year-old woman who came in for work-related stress. So we've been talking a little bit in session. Her main reason for coming in is she's been an administrative assistant for about five years at a company. She keeps working more hours,

doing things for her managers and supervisors and she's never feeling appreciated at work. So, due to the fact that she keeps trying, she's feeling burnt out.

Supervisor: She came to see you for stress-related problems. She's been putting in a lot of hours and she doesn't feel appreciated for all the work that she's doing.

Therapist: No, so her work-life balance has been completely off, and the more she does and doesn't feel appreciated, the more tired and frustrated she gets.

Supervisor: She's at the point of burning out.

Therapist: Yes, and that's why she came in.

Supervisor: You've seen her four or five times?

Therapist: Yes, four or five times. Her history. She's married. She's been married for about 10 years. That's another topic that has come up. She has two children, nine and six. And she's also feeling burnt out at home. She states that she does a lot for the kids and her husband. Her husband does not reciprocate; she doesn't feel very appreciated by her husband. She just kind of takes over and does things so she doesn't really get a break anywhere.

Supervisor: Do you have any information about her family of origin? How things were there for her?

> (Supervisor asked for this information to assess whether there are predisposing factors such as feeling not loved or inadequate because of constant criticisms.)

Therapist: She's talked a little bit about it. She describes her parents' marriage as good. She does describe her mother as being very critical. When she was younger, even looking at her first memories with her mother, she was saying that nothing was ever good enough. She would draw her mother a picture when she was little and her mother would comment how

her drawing skills were not very good, not as good as she would like them. For her, she lived in a household where she felt that nothing was ever good enough for her mom. She had a good relationship with her father. He was a very quiet man. But he wouldn't stand up for her when her mom was being critical. He actually got a lot of the brunt of her mother's criticism as well. That was difficult for her to see.

Supervisor: When you look at the three situations: work, home, and her marriage, it seems that the same theme emerges, and that is that she doesn't feel appreciated and validated for what she does.

(Feeling not appreciated and her work not being good enough appear to be a predisposing factor.
This implies that when she hears statements that sound like criticisms, her old feeling of not being appreciated and good enough emerges.)

Therapist: Yes. Not only that, she takes it on as her own. So, she will never say the responsibility lies with her managers. It is that she's not trying hard enough.

Supervisor: In many ways then she feels it's of her own doing rather than something coming from the outside.

Therapist: On some level she knows it's coming from the outside but she has a pattern to take it in as her own.

Supervisor: The main theme in all of this, from what you've said, is a feeling of [being] unappreciated and not validated for her contributions and for what she does.

Therapist: She definitely does not feel very validated by anyone in her life.

Supervisor: Any other feelings that she might have in these different situations? In her work and at home and from the family of origin?

Therapist: So, not feeling validated definitely is the big one. Um, there's a sense of not feeling confident or good enough as well.

Supervisor: She doesn't match up?

Therapist: Doesn't match up.

Supervisor: When you look at these two themes: not being validated and not matching up. Looking at these two themes from your theoretical perspective, the one you use for your own practice as a psychotherapist, how would you explain them? What concepts could you turn to in order to explain these two experiences?

(Supervisor asks supervisee to draw constructs from her theory which are helpful to conceptualize her problem and to plan treatment.)

Therapist: Well I definitely feel that her mother who is critical, the critical parent, she has internalized the critical parent as her own. So that's something that takes over for her.

Supervisor: In some ways then, she's predisposed to feel not matching up and not good enough and predisposed to feeling that she's not appreciated. As she's mentioned, she has internalized her critical mom. So Mom doesn't even have to be around; she's internalized; she's in her mind. Any other concept that would explain some of the things that she's experiencing?

Therapist: I definitely feel that she hasn't embraced her need to be validated. That's something that keeps coming to me. Because of the critical part of herself she doesn't have a huge awareness of how the need for appreciation is playing a big part in this and that need of hers to feel validated and to feel good enough.

Supervisor: You feel then that the critical parent will act as a barrier to her accepting her competency and also receiving validation from others.

Therapist: Yes, definitely.

Supervisor: How do you intend to proceed with her? What interventions are you thinking you might be able to use with her?

(Given the deeper underlying problems, the supervisor asks supervisee how she intends to proceed in therapy.)

Therapist: First of all, in terms of interventions, um, I think the goal for her is to be aware because I don't think she's very aware [that] she needs validation right now. So in terms of some interventions that I'd use for her is to become aware of that, is I was thinking, you let me know but, maybe focusing. To be able to increase her awareness that she really does need to be validated.

Supervisor: Okay, you're actually talking about the goals first before we talk about interventions which is great; I like that. So, you mentioned a goal would be to help her become more aware and you would use focusing for that.

Therapist: I was thinking that.

Supervisor: Any other goals that you have in mind?

Therapist: Well, if we can get her to be aware that she does need validation, she really needs to; I feel that she doesn't assert herself or her needs at all. In work and at home, even with the kids to kind of have a break. So I think that she needs to start asserting her needs as well. That would be a big one for her if she could get to that awareness.

(Supervisee points out the need not just for awareness but also for action, to become assertive about what she needs at home and at work.)

Supervisor: Do you anticipate any difficulty in her being able to assert her needs, with her husband and at her place of work?

Therapist: Yeah, I could see some difficulty for sure. I think she would like to but that critical parent kind of stops herself from asserting her needs.

Supervisor: Acts as a barrier.

Therapist: Definitely acts as a barrier.

Supervisor: Now in your work with her, do you anticipate any ethical issues or any legal issues?

Therapist: Oh no, definitely none at all with her.

Supervisor: In terms of her readiness to tackle her problems, and that means beginning to assert her needs and feel that she's validated, to what extent is she motivated to work on these issues?

Therapist: I think there's some ambivalence there. She wants to but she "yes buts" a lot in session with me, so I'm feeling that there's some resistance.

Supervisor: To summarize then, you presented a person who's struggling with not feeling validated and not feeling good enough. You were able to see that this permeates her relationship with her husband and at her work and has its origin in the family. And you specified as goals helping her to become aware of the fact that she does have a need to be validated. Another goal is to help her to become assertive, asserting these needs. And then you mentioned that what you would try to do with her is help her become more assertive by using focusing and helping her to assert her needs by using imagery.

Therapist: Well, I think would be a good idea. I was thinking about that. Even task-directed imagery. She can start practicing in session.

Supervisor: Anything else that you would like to add?

Therapist: No, I think that we are going in a good direction. I just wanted to check with you to see if it was, if this is… it really helped me to talk to you to help focus on what our next steps need to be.

Supervisor: Okay, thank you very much for coming in and taking about your session.

Therapist: Thank you.

Concluding Comment

Jessica, an intermediate-level therapist, requested a supervision meeting with her supervisor to receive feedback about her approach in working with the client. Although Jessica saw the client between four to five times, this was the first supervision session regarding this client. Because this was the first supervision meeting, the supervisor wanted to have sufficient background information so that he could make his own assessment about the presenting problem and how to proceed therapeutically. The supervisor also wanted to know whether the client's problem was brought on by the work setting and home situation, or whether the client's difficulty around not feeling appreciated and not feeling good enough is something that she has experienced from a very young age and therefore functions as a predisposing factor.

The treatment will differ if the problem is primarily work-related and home-related or if indeed she has always felt not appreciated and not good enough. In the first instance, therapy would focus on the situations and learn how to change them or how to cope with them. In the second instance, the therapeutic work also involves transforming what Bowlby (1969) would refer to as an "internal working model" (p. 82). Assuming that the latter was the situation, the supervisor asked Jessica to identify the theoretical constructs that would guide her conceptualization and treatment approach.

Therapist-Client Relationship-Focused Supervision

The second focus of the Process Model of Supervision is the therapist-client relationship. This focus comprises two modes of the model, namely Mode 3 and Mode 4. Mode 3 focuses on the therapy process and Mode 4 focuses on the supervisee's countertransference. The supervisor and supervisee's activities, interactions, and relational issues for the two modes are summarized on Table 2.4.

Mode 3. Focusing on the therapy process

The focus of this mode of therapy is not on the client, nor the supervisee, nor their interventions, but rather on the "system that the two parties create together" (Hawkins & Shohet, 1989, p. 63). The supervisor pays particular attention to what was happening consciously and unconsciously in the therapy process. The supervisor might ask questions such as: How did you meet? How did the client choose you? What did you first notice about the client? How did the session start and finish? Other questions that the supervisor might ask are: Find an image or metaphor that represents the relationship, or imagine what type of relationship you would have if you were both cast away on a desert island (Hawkins & Shohet, 1989, p. 63). The supervisor might also ask the supervisee to "Imagine being in the skin of the client and experience what that is like for you" or "If you were close friends, what would that experience be like for you?" This helps the supervisee to understand the client empathically which provides a context to understand the client conceptually.

The purpose of the questions and supervisee images of the relationship is for the supervisee to be able to stand outside of the therapy relationship in which they might be enmeshed or submerged, and to see the dynamic and pattern of the relationship. These techniques help the supervisee to see the relationship as a whole rather than staying with their perspective from within the relationship. Therefore, the main goal of this form of supervision is for the supervisee to have greater insight and understanding of the dynamics of the therapy relationship.

Role of supervisor

1. The supervisor's task is to use interventions to help the supervisee view her relationship with the client in perspective and as a whole.
2. The supervisor listens to the relationship when the supervisee is describing it from within her own perspective. The supervisor listens for the interactive relationship between client and supervisee without taking sides. The supervisor attempts to understand the dynamics of the

relationship; he listens for images and metaphors that emerge as the supervisee describes the client.

3. The supervisor listens for client transference. The questions suggested above and the images and metaphors will give clues regarding client transference. For example, if a therapist described the therapeutic relationship as being like two sparring partners in a boxing ring, this would be very different than if the therapist responded by describing their relationship as being like a frightened rabbit wanting to cuddle up to its mother (Hawkins & Shohet, 1989, p. 64).
4. The supervisor listens to how the unconscious mind of the client is informing the therapist as to what the client needs and how the therapist is helping or getting in the way. One way of doing this is to listen to the client's stories and the feelings that they have about other people and then to decode the client's latent and unconscious communication and relate it to the interactions of the therapist and how they were unconsciously received by the client (Hawkins & Shohet, 1989, p. 64).
5. The supervisor must help the supervisee to differentiate between a client's libidinal needs that need to be frustrated and growth needs that need to be met (Casement, 1985, p. 171-172). Hawkins and Shohet (1989) provide an example from a therapist that they supervised to illustrate the difference between libidinal needs and growth needs:

   > The therapist was a female worker who looked and acted in a motherly fashion. The client was a female whose own mother had been very depressed, often not leaving the house for weeks at a time. The client went through periods of *wanting* the therapist to hug and cuddle her and of trying every way possible for the sessions to overrun the ending time. The *libidincal demand* was for unboundaried symbiotic mothering, whereas the *unconscious growth need* was for a therapist who would provide the clear boundaries that her own mother was unable to give her. Once this had been realized in supervision, the therapist's anxiety with this

> client lessened considerably and she was able to set clear boundaries for the client, in a way that the client was able to accept. (p. 65)

Mode 4. Focusing on the supervisee's countertransference

The supervisor concentrates on the internal processes of the supervisee and how these are affecting her therapy with a particular client. The supervisor looks particularly at the supervisee's countertransference. Hawkins and Shohet (1989, p. 65) emphasize the importance of distinguishing between four types of countertransference: (a) transference feelings stirred up by a particular client; (b) feelings of playing the role transferred on her by the client (e.g., the role of a mother); (c) feelings and thoughts used to counteract the client transference (e.g., avoids accepting mother transference by becoming more masculine and businesslike); and (d) projected client material taken in somatically, mentally, and psychically by the therapist.

The authors suggest that the four types of countertransference have in common the fact that they involve some form of a predominantly unaware reaction on the part of the therapist towards a client. In this sense, the authors' notion of countertransference resembles the classical model since they indicate that the person is not aware of the origin of the countertransference or to what experience the countertransference is related to.

Role of supervisor

It is important for the supervisor to help the supervisee explore all forms of countertransference so that she will be free to respond authentically to a client. In working with countertransference, one cannot help but make reference to a client's transference. In helping the supervisee work through the countertransference, the authors use various techniques such as the following:

1. The supervisor can use a technique called “Checks for Identity” (Hawkins & Shohet, 1989, p. 66) which takes a supervisee through four stages in order to elicit any transference from a previous person. In Stage 1, the supervisee is asked to share her first spontaneous response to the following question: What does this person remind you of? In Stage 2, the supervisor asks the supervisee: What would you like to say to the person? What is unfinished with that person? In Stage 3, the supervisor asks: In what way is the client different from this person? In Stage 4, the supervisee, in role-play, discovers what he would like to say to her client (Hawkins & Shohet, 1989, pp. 66-67). This technique, however, is not able to access the unconscious material.
2. Another technique to elicit supervisee countertransference is for the supervisor to ask the supervisee to free associate to images, metaphors, and Freudian slips when describing a client. From these free associations strong feelings can emerge that then are related back to the client.
3. The supervisor may use a technique referred to as Ideological Editor (Kevlin (1987) which is useful to determine how a supervisee views a client through the supervisee’s “belief-and-value system” that includes her assumptions such as racism, sexism, and prejudice which colours how the client is seen (Hawkins & Shohet, 1989, p. 67). One way to elicit this ideological editor is an awareness of the supervisee’s use of comparatives. For example, if the supervisee describes a client as obliging, the supervisor might ask: “In what way is she obliging?” or “She is obliging when compared to whom?” or “How do you think that clients should oblige you?” (Hawkins & Shohet, 1989, p. 67). In asking these questions, the supervisor seeks to discover the assumptions as to how clients should be.

Illustration: Therapist-Client-Focused Supervision

Introductory Comment

The following transcript is taken from a videotaped role-play by an intermediate-level therapist, Jessica, and her supervisor, Augustine. The transcript illustrates the articulation of a countertransference, how it is triggered by experiences of early childhood, and the manner in which the therapist intends to manage this transference when seeing the same client.

In order to have a whole picture of their relationship rather than staying with her perspective from within the relationship, the supervisor asks the therapist for an image that would depict their relationship and their struggle. She pictures their relationship as a boxing match with Jessica losing the fight. Through an analysis of her own reactions, Jessica becomes aware that when she is with this client, she feels not good enough, a feeling that she experienced repeatedly as a child in her relationship with her father. She then makes the link that when she is with the client, she responds from the position of a five-year-old child rather from her adult position. To manage her feelings towards the client and to feel comfortable when with the client, Jessica decides that she will try to put aside the reaction of the five-year-old and respond from her adult self.

Transcript of Supervision Session

Supervisor: How are things going at the office these days?

Therapist: Things are good but there's a particular client I want to bring up to you. I'm a little bit embarrassed because it's the last one we ended with on our last supervision. I'm feeling very frustrated and very stuck.

Supervisor: For how long has this been going on?

Therapist: Since session one.

Supervisor: Session one.

Therapist: Well maybe two. Because there's something that is happening and I'm not sure what's going on.

Supervisor: If I were to ask you for a picture or some kind of image, if I were to be on the outside watching what's going on, what would I see?

(The supervisor asked for an image of their relationship so as to have a whole picture rather than to see it from the perspective of one or the other within the relationship.)

Therapist: That's a good question. I feel like I'm in a boxing match with my client. That's the best way to put it. And I'm losing. I've maybe won two rounds but we're on round two hundred, it feels like, and I'm just loosing [*sic*] badly.

Supervisor: What is it that gets you engaged in this boxing match with the client?

Therapist: I don't know what seems to be going on. I come into session and it's been seven sessions and every week I'm exhausted before I go in. Um, but I go in. This person seems like they want my help. Then next thing you know I'm helping and they're almost bullying me in the session. And I don't know how we get there but at the end I just feel like I've been bullied.

Supervisor: Pushed around?

Therapist: Like completely pushed around. I'm embarrassed, like I'm the therapist and I'm getting bullied in session. I'm feeling that way maybe I'm just… I don't know.

Supervisor: Do you have any sense [of] what the client wants from you? What is she trying to get from you? What are her expectations?

(The purpose of this question is to understand what client needs are not being met which frustrates the client and leads to her bullying behaviour.)

Therapist: I have no idea. I feel like she says she wants help, but apparently, she doesn't. This is the client, remember, she doesn't feel validated at work, doesn't feel heard with her husband. I almost understand why her husband doesn't hear her, which is awful for me to say. But I just, I

know she doesn't feel heard. Maybe that's what she needs. She needs to feel heard but she doesn't really let me hear her. So, it's frustrating. I'm frustrated.

Supervisor: You are both frustrated in the session. You're frustrated; she's frustrated.

Therapist: I guess so. Maybe I'm just not giving her what she wants.

Supervisor: I'm sure you heard me say many times that feelings are like a thermometer. A thermometer indicates when it's cold or hot. In a similar way, when a person has what is needed, she feels happy and joyful, and when something important in life is missing, she feels sad, frustrated, angry, and so on.

Therapist: Yes. I remember hearing that.

Supervisor: Looking at it from relationship psychotherapy, we see that it is unmet needs that are causing the negative feelings. When [we] speak about unmet needs, we consider both unmet childhood needs and unmet adult needs. We differentiate between the two. Unmet childhood needs are needs that were not met when the child was young and they're still there in terms of longings and yearnings. They won't relent. Whereas adult needs are very different because when they are met a person's sort of satisfied and can go on with their work. It's not like that with a yearning or a longing. If we think, then, in these terms, in terms of needs, and if you think about your client, what would be the unmet need for your client? The need that she is trying to get you to respond to?

Therapist: I'm guessing in terms of relational or self, maybe the need to be lovable or lovability. Definitely competence resonates for me. But again, I can intellectually know the needs but as soon as I get into that room, they just kind of go out the window a little bit.

Supervisor: Thus, your feelings take over when you're there with her. We can talk about these needs in different ways. One way would be, for an

example, if you were to meet her in the mall or meet her in a coffee shop, what would be your initial reaction to her?

(The supervisor helps the supervisee to determine the client's needs with reference to behaviours and interpersonal reactions.)

Therapist: To run and hide. No. If I was having a coffee, it would be kind of one or the other. It would be just kind of avoid the situation and let her get her way. Or I'd feel like what sometimes happens in session… it's either letting her get her way or I over compensate [*sic*] and almost start fighting with her, in session. And I think that's where the boxing match comes in, I guess. It's embarrassing; I'm fighting with my client. Then she leaves and I'm just like, 'what has happened?'

Supervisor: Your initial reaction, then, is to become engaged with the client and get in a boxing match with her.

Therapist: It doesn't feel like I'm getting engaged in a healthy way.

Supervisor: Another way to look at that is for how you are being drawn in. What does it feel like when she's trying to draw you into this boxing match? And in some ways, you're resisting it. What other feeling do you have besides you're just trying to resist it?

Therapist: I don't know if this is correct. I want to help her so I kind of get into that boxing match, and then once I get in there, I feel like she's fighting me so I have to fight back. Is that kind of what you mean?

Supervisor: And whenever you're engaged in it… how are you trying not to let yourself get engaged in it? What kind of things are you saying to yourself? What are you thinking of?

Therapist: I think I'm just feeling so threatened at the time. I don't really know how to get out of it. I feel like I'm in a flight or fight mode because I'm not feeling… I'm just feeling bad about myself.

Supervisor: Mhm, and another way of looking at it is in terms of how you feel after the session, such as when you go home. Do you carry any of these things with you? Do you feel it bodily? Could you say something about that?

Therapist: It feels awful. This is the only client I have where I gear up for the day and I have it in my throat and this ball in my chest that gets worse and worse. I think once I'm done the session it will get better but it actually just says [*sic*] there. I just go home re-thinking about the session and what I did wrong. I do all of my readings and it's just not helping and I think I've prepared for the next week but it just happens again.

Supervisor: That which we're talking about is to help you get more in touch with your feelings, your countertransference. We looked at four different aspects. First, if you were to meet the person outside of therapy how would you feel. Second, we mentioned how you try to not let yourself be drawn in. Thirdly, you mentioned what's going on in your mind and how you're trying to fight it off. Fourth is how you feel after the session, bodily and psychologically. Now, I'm just wondering in your relationships of the past have you met anybody where you had similar or the same kind of feelings?

> (The purpose of this question is to identify a potential predisposition to respond to controlling persons in an aggressive way and, if so, to uncover the unmet needs and underlying dynamic.)

Therapist: Um, well I had a lot of bossy friends when I was growing up, so definitely them. I guess if I have to be honest, it would probably be my dad. My dad was pretty aggressive when I was a child. I didn't really have a chance to speak; there's a lot of not feeling good enough, which happens a lot in session. I don't feel good enough a lot of the time. I have to either fight it or just kind of let it happen almost. So, yes, I definitely see that link for sure. I feel like I'm five years old in the session most of the time.

Supervisor: In some ways then this feeling that you're not good enough is a familiar feeling.

Therapist: Definitely.

Supervisor: And is easily triggered by the client that you're speaking of.

Therapist: Yes.

Supervisor: When you were young, when you were a child, you felt that there was not much that you could do about these feelings, and today, when you're with your client, these same feelings come to you. What would you like to say to these feelings, to the feeling that "you're not good enough as a therapist," "you're not doing good enough of a job," [and] so on? What would you like to say to that?

> (The goal is to look at different ways to respond to such feelings and to empower the therapist by having her challenge her feeling and belief that she is not good enough as a therapist.)

Therapist: I feel like my five-year-old is driving my bus when I'm in session so I feel like I need to maybe take her out of the chair and put her somewhere else in my mind and just visualize me being in the chair as an adult. I'm starting to see that she's driving the session. She's the one in session, not the therapist.

Supervisor: And she's triggering the unmet childhood need to feel good enough. You are being put into the child position rather than into the adult position.

Therapist: And probably, to be honest, interacting with her from my child not my adult. Which is hard.

Supervisor: In discussing this client, you have become aware that she triggers in you the feeling of not being good enough. This is a familiar feeling and triggered by statements from others that make you question your own abilities. You mentioned that you realize that this reaction comes

from the position of a five-year-old and not from the position of your adult self. You mentioned that the client likely needs to be heard but she makes it difficult for you because [of] how she is. But you will try to remain focused in responding to her from your adult position. I am wondering, how has it been for you to speak about your struggles with this client and whether talking about it has been helpful.

> (The supervisor indirectly asks the supervisee to articulate her insight that her reaction to her client reflects a relational pattern she learned in childhood to cope with her feeling of not being good enough and that this feeling continues to influence her reaction to persons who are perceived to be controlling and bossy.)

Therapist: Well, first of all thank you because I thought I was a bad therapist and I didn't know. I'm embarrassed to say that I don't like a client. So it was nice that there's actually something going on, not just me feeling like a crappy person for not being able to do my job. So thank you. The other thing I think is knowing that link is going to help me put my stuff aside. I will probably relate to her a lot differently, probably a lot more empathic. I'm thinking even just as we're talking… coming at it more from an adult point. It probably seems that she's got a lot of unmet needs similar to mine, maybe that's why I'm being triggered. So I can kind of take a step back a bit. I think that's definitely going to help in our next session. I just need to keep reminding myself that I'm not five and so to just keep taking that little girl out of the room.

Supervisor: You mentioned two things. One is to be able to self-evaluate and validate yourself and say "I am doing a good job," and you're okay with that. And the other thing you mentioned is being able to understand your own stuff will help you to understand her and become more empathic towards her.

Therapist: Yes, because I think I am doing a good job. It's just… I just think her defences are really triggering.

Supervisor: And you want to stay in touch with that self-validation and not let that other part get in the way.

Therapist: I think that will be a good idea.

Supervisor: Anything else you would like to add to our session today?

Therapist: No. That was very helpful; I think I'm just going to take it and run with it. I feel a lot better about the whole situation.

Supervisor: Okay, well thank you very much.

Concluding Comment

In the supervision session, which seemed like a therapy session, the supervisor played the role of a counsellor to help the supervisee come to an understanding of her reaction to the client who was perceived to be bossy and conveying the message that the supervisee was not a good enough therapist. The supervisee came to understand that her sensitivity to criticism had its origin at a very young age in her relationship with her father. She is predisposed to feel not good enough when being pushed around. She came to realize that both she and the client are likely struggling with the same sensitivity to feeling not good enough. This awareness helped the supervisee to be more empathic towards the client. In her future sessions, the supervisee will make efforts not to respond from her five-year-old child, but from her adult self. This will help her to take some distance from the client's own struggles.

Supervisory Relationship-Focused Supervision

In Modes One to Four, the supervisor focused outside of herself. In Mode One, the supervisor focused on the client; and in Modes Two to Four, the focus gradually shifted to that of the supervisee. The supervisee was encouraged to look less for answers regarding the client's problems and to pay more attention to what is happening in her own person. The supervisor, too, had not as yet started to look inside the supervisee as to what is

happening. In the final two modes, the supervisor "attends to the client's therapy by focusing on how the client's psychodynamics enter and change the supervisor relationship and then in Mode Six how these dynamics affect the supervisor" (Hawkins & Shohet, 1989, p. 68).

Mode 5. Focusing on the here-and-now process as a mirror or parallel of the there-and-then process

In Mode Five the therapeutic relationship is explored as to how it is mirrored in the supervisory relationship. This mirroring was discovered and explored by Searles (1955) and referred to as paralleling phenomena. Searles (1955) contributed substantially to the psychotherapist's understanding of Mode Five of supervision. (See above for more detailed description of parallel processing). Parallel process refers to the supervisee relating to the supervisor in a similar way that the client relates to the supervisee. By focusing on the relationship between supervisee and supervisor, one can uncover the nature of the relationship between client and therapist. To say it differently, parallel processing refers to the client-therapist relationship being reflected in the supervisee-supervisor relationship. For example, if the client is retentive, then the supervisee when with the supervisor might unconsciously be retentive (Hawkins & Shohet, 1989, p. 69).

Parallel processing can be considered in a second way where it refers to the re-enactment of the supervisee-supervisor relationship or dynamic in the supervisee-client relationship following a supervision session. For example, if the supervisor is understanding of a supervisee's holding back, and she explores it patiently and gently, then the supervisee reacts in the same way with a retentive client in the following session.

Role of supervisor

The supervisor focuses on the relationship in the supervision session in order to explore how it might be unconsciously playing out or paralleling the hidden dynamics of the therapy session (e.g., therapist playing out

client's passive aggressive behaviour). An important skill in working with paralleling is for the supervisor to notice her reactions and to feed them back to the supervisee in a nonjudgmental and supportive way. For example, the supervisor might say, "I experience the way you are telling me about this client as quite withholding and I am beginning to feel angry, I wonder if that is how you felt with your client" (Hawkins & Shohet, 1989, p. 69). In this example, the supervisor is in touch with her own countertransference relative to hearing about the supervisee's client.

Mode 6. Focusing on the supervisor's countertransference

In Mode 6, the focus is on how the therapeutic relationship enters into the internal experience of the supervisor (Hawkins & Shohet, 1989, p. 70). The supervisor, in this mode, primarily pays attention to her own here-and-now experience in the supervision, or to her countertransference, including what feelings, thoughts, and images the shared therapy material stirs up in her.

At times a supervisor might experience a change come over her; suddenly, she might feel tired, be overcome by incomprehensible fear, or become sexually excited by her image of the client. These "eruptions" are important messages from our unconscious receptors as to what is happening in the here-and-now in the room and out there in therapy. In order to trust these eruptions, it is important for the supervisor to know her own process well; that is, she must know when she is normally tired, fearful, bored, and sexually aroused in order to ascertain that this eruption is not entirely her own inner process bubbling away but that it is received from the outside. In this process the "unconscious material of the supervisee is being received by the unconscious receptor of the supervisor, but the supervisor is tentatively bringing this material into consciousness for the supervisee to explore" (Hawkins & Shohet, 1989, p. 71). The supervisor uses these responses to provide reflective illumination for the therapist.

It is important for the supervisor to be clear about her countertransference towards the supervisee and ask questions such as: "What are my feelings towards the supervisee?" or "Do I generally feel bored, threatened,

critical?" The goal here is not to work through the supervisee transference but rather to remain in an adult-to-adult relationship. Hawkins and Shohet (1989) state that "unless supervisors are relatively clear about their basic feelings to the supervisee, they cannot notice how these feelings are changed by the import of unconscious material from the supervisee and their clients" (p. 71).

In order to use this mode of supervision, it is important for the supervisor to not only be aware of her processes, but also to be able to attend to her own shifts in fantasies, sensations, and thoughts while still attending to the supervisee. Supervisors, mindful of their own countertransference, might make a statement such as:

> While you have been describing your work with X, I have been getting more and more impatient. Having examined this impatience it does not seem to do with you, or something from outside our work together, so I wonder if I am picking up your impatience with your client. (Hawkins & Shohet, 1989, p. 71)

Thus far, this model has explored the dialectic between two relationships, namely that of the client-therapist and the supervisee-supervisor. There is a third side to this triangle which is the fantasy relationship between client and supervisor. The supervisor might have all kinds of fantasies regarding the supervisee's client although he has not met them and the client might have similar fantasies about the therapist's supervisor. This relationship also needs to be addressed.

Mode 7. The supervisor helps the supervisee to focus on the organizational, social, and political context in which the work is taking place

The six-mode supervisor model just presented includes all of the processes within both the therapy and supervisory matrices. However, the supervisory relationship exists within a larger context which places restraints on the processes within. The client-therapist-supervisor threesome

exists in a real world where there are professional codes and ethics to live by, organizational restraints, expectations, needs, and relationships with other agencies (Hawkins & Shohet, 1989, pp. 75, 140-152).

It is important for the clinical supervisor to ensure that the supervisee's professional competence is equal to the responsibilities and unique expectations of their respective jobs. When reviewing cases, supervisees should be helped to develop the skill of conceptualization, that is seeing the bigger picture rather than focusing too narrowly on specific diagnostic criteria. It is important to understand the needs and challenges of the whole person so as to provide an appropriate framework for effective case management and service planning.

This approach to supervision is also essential for organization and institutional satisfaction and successful service planning. Supervisees working in institutions are to be guided in developing the broader foundational skills in engaging the consumer (i.e., institution or organization), building rapport, and involving them in the planning of services. In planning services, the supervisee needs to be guided to identify and incorporate the consumer's personal goals, strengths, expectations, cultural uniqueness, and past experiences. Clinical supervisors should also strongly encourage their supervisees to arrange for consumer feedback at the end of each engagement to evaluate their level of effectiveness using the consumer DBHS Practice Protocol (Arizona Department of Health Services, 2008).

Illustration: Supervisor-Therapist-Focused Supervision

Introductory Comment

The client presented in the following transcript is the same as was presented in the first two foci of supervision. The supervisee scheduled a meeting with the supervisor because she was becoming very frustrated with the client who did not become engaged in the therapy session and tended to pick a fight with the therapist. The supervisee questions whether there is

something wrong with how she is proceeding with the client in therapy or whether there is more to it than that. In her interaction with the supervisor, the supervisee acts in the same way that the client has interacted with her; that is, she tends to oppose the supervisor's suggestions.

The supervisee's goal is to understand the client's oppositional behaviour towards her approach to therapy and also to understand what it might be in the supervisee that contributes towards the oppositional behaviour. The task, therefore, is for the supervisee to understand the client's transference and her countertransference and learn how to manage both.

Transcript of Supervision Session

Supervisor: Good afternoon, Jessica.

Therapist: Good afternoon. Thank you so much for seeing me on such a short notice. The client that we talked about last week… It feels like it's been a year… it's only been several weeks. I'm stuck. I tried everything, every technique in my tool box and nothing is working. So I just thought coming to supervision a little bit earlier we could talk about some interventions that I haven't tried. So, we are primarily dealing with coping tools of work. We did Gestalt two-chair… that did not go well. I'm completely out of options to get her to connect to herself.

Supervisor: You've tried many things and she's not collaborating with you, not going along with your interventions.

Therapist: Not at all. Everything. I feel like I'm just getting smashed down every session.

Supervisor: Do you have any particular goal in mind in terms of what you want to achieve in therapy at this point in time?

Therapist: Well, Augustine, I don't think it's that simple. We're looking just at coping tools to try to kind of open her up to her inner child as we

talked about last week, but she doesn't want to open up to her inner child. She wants to but she doesn't and I don't understand.

Supervisor: You have as a goal to help her to get in touch with her inner child and to have her to open up?

Therapist: Well that was the first couple sessions but since then everything I'm doing is ridiculous.

Supervisor: In her mind?

Therapist: Oh yes, in her mind.

Supervisor: I'm wondering, have you tried the focusing technique? You know that's a technique that helps people get in touch with the bodily awareness and then that can help them to open up.

Therapist: Augustine, I don't think that's going to work at all. Remember our third session I was talking with her… she won't go there, she just won't. I just don't think any experiential techniques are going to work for her.

Supervisor: In all of the things you've tried, all you've experienced from her are road blocks and barriers and she's not ready to collaborate with you and not willing to follow your directions…

Therapist: I don't know. I guess so. So I need your help to kind of, give me something I can use with her because I'm out of stuff.

Supervisor: As I'm sitting here and listening to you tell the story of the client and describe your experience with the client, I'm beginning to feel ill at ease, a bit impatient and frustrated. As I'm thinking about it, it's not coming from you.

Therapist: Okay, good.

Supervisor: I don't think it's coming from you. I don't believe it's coming from the work we're doing together. I'm just wondering if I'm not picking

up your own impatience working with this particular client.

Therapist: I am impatient. I am impatient all the time. I don't even know if I'm trying things anymore because she just says no to them. So it is I'm impatient and I'm frustrated. No, exactly, I keep thinking I'm doing something wrong, but no, she's just frustrating.

Supervisor: I'm just wondering then – you heard me say that I'm beginning to feel impatient and frustrated too. And you just mentioned that you feel the same thing. I'm wondering how you feel hearing me say that I have the same feelings that you do. That I can resonate with what's going on within you.

Therapist: I'm feeling validated and not alone. She's making me feel like this and you also. There must be something more to this. I kind of keep coming back to "what am I doing wrong?" No, I think this is just what she does.

Supervisor: Knowing that I also feel the same way is validating?

Therapist: It makes me feel that this is just what she does [and] that it is not a reflection on me.

Supervisor: You have been speaking [about] how frustrated and impatient you are with your client and wondering whether there was something wrong with you or whether it was the client. You also heard me say that in listening to you speak about your client, I began to feel impatient but I did not think that this was coming from you, but from the client. I am wondering then, how has it been for you to talk about your experience with the client?

Therapist: Well it's good because at least I know that this is a defence instead of feeling that I'm just a bad person. But something also, that you were impatient… I'm really sorry that I was just throwing stuff at you. I kind of feel like I was doing… I don't know if you picked up [on] this… I kind of did what my client does. Because she kind of comes at me similarly.

I don’t know where that came from. You talking to me like that made me feel that maybe that is how I need to talk to her when she’s feeling this way, because I feel better now, almost.

Supervisor: You sense then that you were being like the client when with me.

Therapist: A little bit… and that’s never happened before.

Supervisor: You know there is a terminology we use to describe this kind of behaviour; I don’t know if you’ve heard of it or not but we call it parallel processing.

Therapist: No, I haven’t.

Supervisor: Parallel processing has two meanings. One meaning is that the supervisee, when she sees the supervisor takes on the role of the client without her knowing about it, the supervisee speaks to the supervisor in the same way that the client spoke to the supervisee. A second meaning is that in parallel processing the supervisee begins to relate with her client in the way that the supervisor related with her.

Therapist: Okay.

Supervisor: This is not an unusual experience within the supervision relationship.

Therapist: Good, because… I almost feel that I have an insight into her, a little bit more of an insight into what she’s going through with me. I can see me reacting badly isn’t helping. So I can definitely... I guess it’s okay if I model how you explored that with me and I’ll probably take it into our next session. I hope it goes well. I think it will go well.

Supervisor: How are you with everything right now?

Therapist: I feel good. I feel that I’m not in my emotions anymore. I feel validated that this isn’t just me.

Supervisor: It's just a part of being a therapist.

Therapist: Just part of being a therapist.

Supervisor: Anything you would like to add to our meeting today?

Therapist: No, I think I'm going to take that stance with her next time just to kind of go deeper into her frustration.

Concluding Comment

In her interaction with the supervisor, the supervisee became aware that she was interacting with him as the client had interacted with her. She initially opposed what the supervisor was suggesting in the same way that the client was opposing the supervisee's efforts. The supervisee thought that her relationship with the client was due to her being a bad therapist.

As the supervisor listened to the supervisee describe the interaction between herself and the client, he began to feel impatient and frustrated. He shared this feeling with the supervisee and suggested that it was not coming from her nor from the work they were doing together. He then asked if she might feel the same when with the client. She felt that her feelings were validated. She realized then that her feelings were coming from elsewhere. She became more empathic towards the client. She felt that she could help the client explore her feelings towards the supervisee in the same way that the supervisor helped her to explore her feelings towards the supervisor. At the end of the supervision session, the supervisee felt that she had the tools she needed to engage the client in a more positive way.

Summary

This chapter presents the three different ways in which the supervisor and the supervisee can speak about and address the complexities of his therapeutic work. One approach is to focus clearly on the client and his presenting problems with the goal to theoretically understand the problem and to plan treatment. A second but complementary approach is to focus on

the therapeutic relationship in terms of the nature of the relationship and transference and countertransference issues. The third approach is to focus on the supervisee and supervisor relationship with an eye on how the supervisee might be acting with the supervisor in the same way that the client interacts with the supervisee and for the supervisor to use his countertransference to have an insight into the dynamics of the client.

Theoretical orientations differ in the extent to which they include the three foci in their supervisory practice. Some orientations limit their supervisory practice to focus on the client and only on the client and will pay limited attention to the therapeutic relationship with its transferential and countertransferential issues. Other orientations understand the practice of supervision to include all three foci. The reality is that when clients present problems of a relational nature, there is a greater likelihood that the three foci will become part of the supervision process. As a supervisor, it is important to know the theoretical orientation of the supervisee and his expectations and to tailor supervision accordingly. Although the supervisor's style and natural inclination is to consider the three foci to be essential aspects of supervision, the supervisor's responsibility is to help the supervisee to grow into autonomous and independent practice according to his preferences and talents. The following chapter presents the research on various aspects of supervision.

PART THREE
Research on Supervision

CHAPTER 8

Research on the Effectiveness of Supervision

Introduction

The interest in the study of clinical supervision reached its peak in the 1980s and 1990s with the development of supervision models and with research on the formation of supervisors. However, very little has been added during the past 15 years, seemingly because of the lack of any new interest (Bernard & Goodyear, 2014; Watkins, 2012).

Research on supervision focused almost exclusively on the supervisory alliance and how it affects the achievement of the restorative and formative goals of supervision (Bernard & Goodyear, 2009). There has been very little written on the achievement of formative goals (e.g., supervisor instruction and modelling of therapeutic skills). Even less has been written on how supervisors evaluate the supervisee's clinical competence or how supervisors evaluate the outcome of the supervisee's clinical work with their client (O'Donovan et al., 2011).

Barker and Hunsley (2013) state that in the research of the past 20 years on the development of clinical supervisors, approximately 50% of the studies did not appear to use any theoretical models of supervisor development when formulating their research designs or questions. The theoretical model most often used in research was the Watkin's Supervisor Complexity Model (Watkins, 1990).

It is generally agreed that new models for the development of supervisors are required as well as research regarding the experiences of supervisors as

they move from beginning supervisors to becoming master supervisors. As for new models, Falender and Shafranske (2004) propose a model that views psychological supervision in terms of competencies. The authors provide a framework which includes competencies in the following areas: (1) knowledge (e.g., of models, theories, and research on supervision); (2) skills (e.g., relationship skills and teaching skills); (3) values (e.g., respectful and empowering); (4) social context overarching issues (e.g., ethical and legal issues); (5) training and supervision competencies; and (6) assessment of supervision competencies (e.g., successful completion of course on supervision).

Goodyear, Lichtenberg, Bang, and Gragg (2014) suggest that supervisor development be considered in terms of themes rather than in terms of continuous stages. The authors modified the ten strands of supervisor development that Heid (1997) culled from the literature and then surveyed supervisors to determine their relative weight. The authors identified ten themes among which are: becoming able to perceive/act on complex response opportunities; learning to think like a supervisor; developing the ability to be oneself; and learning to view oneself as a supervisor (p. 1044).

Regarding research findings, very little is known about the interior experience of the developing supervisor. Even less is known about how a "supervisor's internal life (e.g., cognitions, affect, self-efficacy), skill level, and supervisor identity formation change as they acquire knowledge, training, supervision, and practical experience" (Watkins, 2012, p. 46).

To develop the field of supervision, in addition to building new models, qualitative research is needed to provide the essential aspects of the supervisory experience, quantitative research is needed to test hypotheses, and new instruments are required to measure the development of supervisors (Watkins, 2012, p. 45). As for the development of instruments, there is some movement in this direction (Orellana & Gelso, 2013). Three of the instruments that have been developed are the Inventory of Countertransference Behavior (Friedman & Gelso, 2000); The

Psychotherapy Supervisor Development Scale (Watkins, Schneider, Haynes, & Nieberding, 1995; Barker & Hunsley, 2014); and the Real Relationship Inventory, Therapist Form (RRIT) (Gelso et al., 2005). Shaffer and Friedlander (2017) are in the initial stage of developing a Relationship Behavior Scale.

One of the more widely used instruments is the Supervisor Styles Inventory (SSI) (Friedlander & Ward, 1984). The SSI depicts three styles, namely the Interpersonally Sensitive Style (ISS), the Task-Oriented Style (TOS), and the Attractive Style (AS) of supervision. Each measure has 33 unipolar items. The ISS has been endorsed by psychodynamic/humanistic supervisors and the YOS has been endorsed significantly more by cognitive-behavioural supervisors.

The following is a summary of the results from the research in the field of clinical supervision. Among the topics researched are the supervision contract, increasing supervisee competencies, and assessing the effect of supervision on client outcomes. Many of the studies are more in the nature of surveys rather than theoretical-based research.

Contracting for supervision

Most writers in the field recommend that at the beginning of supervision an explicit written contract that specifies the goals, tasks, and processes of supervision be negotiated and signed by the supervisor and supervisee (Bernard & Goodyear, 2014). The goals and tasks negotiated should be based on the "supervisee's self-reports of learning needs, developmental stage of supervisee, supervisor evaluation of supervisee strengths and learning needs, overall programme-learning objectives, and clinical context-specific learning needs" (O'Donovan et al., 2011, p. 106). Establishing and agreeing to specific goals enhances self-reflection on the part of the supervisee, provides a clear agenda for supervision, increases the likelihood that supervision time will be focused and effective, and provides a template for evaluating supervision.

In addition to the practical and administrative components of the contract, there should also be a discussion about the nature of supervision and its components and how they will guide the supervisee to good clinical practice. The Association for Counselor Education and Supervision (ACES) Taskforce on Best Practices in Clinical Supervision (2011) published a document outlining best practices in clinical supervision. The ACES grouped the best practices under twelve topics. Among these are initiating supervision; giving feedback; conducting supervision; the supervisory relationship; and documentation. Borders et al. (2014) recommend that the supervision best practices guidelines serve as the foundation for research on the development and expansion of the psychotherapist's knowledge for the best practices in clinical supervision.

The use of a contract, which has become a common practice, is associated with low supervisee anxiety with regards to the supervision process and encourages supervisees to be more open in telling supervisors about their concerns. Supervision can be facilitated via regular discussion of progress towards the goals of supervision (O'Donovan et al., 2011, p. 106).

Methods of supervision

In terms of the methods used most often by supervisors in supervision, research found the following. One study (Ellis & Ladany, 1997) of supervisors and supervisees observed that the practice of clinical supervision consisted primarily of supervisees verbally reporting to their supervisor on what they did in the therapy sessions and how the client has been responding in sessions. As well, the supervisee and supervisor discuss the plans for future sessions.

In a second study (Scott, Pachana, & Sofranoff, 2011), supervisees reported that supervision time often focused on discussion with the supervisor about current and future client sessions based on the supervisee's report of (1) what was happening in the sessions, and (2) the subsequent outcomes. Supervisees reported that supervision varies considerably between supervisors and can include different combinations of: (1)

discussion of therapy content, therapy process, and therapy outcome; (2) discussion of the supervisee-client therapeutic alliance or the supervisor-supervisee alliance; (3) demonstration or practice of specific therapy skills; and (4) reviewing audio-visual recordings of supervisee therapy (O'Donovan et al., 2011, p. 104).

Developing supervisee competencies

Various methods have been used to develop supervisee knowledge and skills. Some supervisors focus predominantly on the supervisor alliance to facilitate supervisee's professional development. Other supervisors use a broad range of teaching strategies to enhance supervisee professional knowledge and skills. Included among these strategies are didactic instruction, guided reading, skill demonstrations and practice, problem-solving discussions, and guided supervisee self-evaluation of therapy content and process. Research has demonstrated that there is no difference between focusing on the alliance or the use of teaching strategies in developing supervisee knowledge and skills (O'Donovan et al., 2011, p. 105).

Promoting and monitoring the quality of supervision

There is no research available to suggest preferred methods of promoting and monitoring the quality of supervision; nevertheless, there are a number of factors that contribute to establishing an effective supervisory process. One method is to provide training in supervision for supervising psychotherapists. Another method is for supervisors to evaluate their performance. Supervisors' self-reports have shown to correlate well with the supervisees' reports of supervision (O'Donovan, Dooley, Kavanagh, & Melville, 2009). Second, given that positive supervisory alliance is associated with positive supervision outcome, it is important to promote the supervisory-supervisee alliance (Lambert, 2010).

Relationship between supervision and supervisee therapeutic skills

A correlation has been observed between positive supervision and a supervisee's perceptions of their clinical skills and self-efficacy as a therapist. However, a supervisee's perception is not the same as competence (Lobban al., 2009). Supervision affects supervisee's skills through both modelling by the supervisor and by the supervisee incorporating explicit supervisor advice into the supervisee's practice (Milne, Pilkington, Gracie, & James, 2003). However, supervision has the potential to be either a positive or a negative influence on supervisee practice (Brosan, Reynolds, & Moore, 2006). Supervision appears to be particularly effective when it is received in the context of curriculum-based training such as clinical coursework (Berg & Stone, 1980). This consistency seems reasonable and the content of supervision would reinforce the supervisee's learning. However, there is no systematic research on how best to coordinate the content of supervision with other training components.

Evaluating supervisee therapeutic competence

Supervisors and supervisees agree that the evaluation of supervisee competence is primarily based on the supervisee's verbal report of what they did in the clinical sessions (Ellis & Ladany, 1997). Similarly, postgraduate clinical psychology students report that their self-report of the contents of their clinical session was the predominant method used to assess their clinical work (Scott, Pachana, & Sofranoff, 2011). The supervisor's direct observation of the supervisee's clinical work was never or rarely used and the supervisor's review of audio-visual recordings of the therapy sessions was used only occasionally by some of the supervisors (O'Donovan et al., 2011).

Supervisory relationship and supervisee well-being and satisfaction

The quality of the supervisor-supervisee relationship impacts the well-being and satisfaction of the supervisee (O'Donovan et al., 2011). A supportive experience reduces supervisee anxiety, enhances their confidence in clinical practice, and enhances job commitment. However, for supervision to have a positive effect on supervisees, the latter must feel the

supervisor's support and feel comfortable to discuss sensitive issues (Edwards et al., 2005). Research shows that the degree of supervisee satisfaction is related to the extent that the supervisor is perceived to be empathic and supportive irrespective of age, gender, and theoretical orientation (Bernard & Goodyear, 2009). This association is not indicative of competency (Milne & James, 2002). On the other hand, poor supervision can be harmful to supervisees. Harmful experiences can include supervisors violating ethical standards including dual relationships; supervisors being demeaning, overly critical, and vindictive; supervisors using their power for gain at the expense of the supervisee; and supervisors publicly humiliating supervisees. Consequences of harmful supervision include excessive shame and self-derogation, loss of self-confidence, and both personal and professional functional impairment (Gray, Ladany, Walker, & Ancis, 2001).

Two aspects of the supervisory relationship that might enhance or detract from the alliance are the phenomena of parallel processing and isomorphism (Clarkson, 1994; White & Russell, 1997; Koltz, Odegard, Feit, Provost & Smith, 2012). In both processes, the therapist presents himself to the supervisor in the same manner that the client presented himself to the supervisee. In the case of parallel processing, which is grounded in psychodynamic theory, the focus is primarily on intrapsychic and internal processes that drive the behaviour whereas in isomorphism, which has its roots in systems theory, the focus is on repetitive structural relational patterns. The processes, however, are bi-directional in the sense that the supervisee after the supervision might respond to the client in the same way that the supervisor responded to the supervisee. It is important for the supervisor to be aware of their own cognitive and emotional process so as to avoid the abuse of power and to detect situations that involve conflict and anxiety to the supervisee (Clarkson, 1994; Kaberry, 2000). In surveys it has been found that supervisors are hesitant to judge a student as incompetent because of the lack of systemic support for the evaluation process, impact that such an evaluation has on the supervisee, and fear that

such an evaluation might undermine the supervisory relationship (O'Donovan et al., 2011).

Evaluating therapy outcomes for supervisee's clients

Supervisees' clinical impressions are the predominant method used to evaluate the outcome of supervisee-delivered therapy. Supervisors judge the outcome or therapy based on the supervisee's impressions of client progress and on what the client reports to the supervisee on outcome (Scott et al., 2011). Supervisees' reports of their impression of client outcome are an inadequate means to evaluate the success of therapy. From the 60-70% of adults who report benefitting from individual outpatient psychotherapy (Hansen, Lambert, & Forman, 2002), 10% deteriorate and 20-30% show no improvement after individual therapy (Lambert & Ogles, 1997). As for couple therapy, a substantial number of clients fail to respond to existing evidence-based couple approaches (Halford & Snyder, 2012); about 10-15% deteriorate, and 15-20% show no reliable benefit from therapy (Snyder, Castellani, & Whisman, 2006).

Research demonstrates that even experienced psychologists are poor at identifying the minority of clients who are deteriorating across the course of therapy; as well, they are poor at detecting the clients who are unlikely to benefit from their therapy (Lambert, 2010). Based on these studies, it is apparent that there needs to be a much stronger emphasis in supervision on detecting poor client response to therapy and to adjust what the supervisees are doing in sessions to enhance client outcomes. Simply knowing that clients did not benefit is not good enough.

Supervision and client outcomes

The pervasiveness of the assumption that supervision enhances outcome is reflected in the standard requirement for conducting psychotherapy outcome research. That is, the therapists who deliver the psychotherapy are to be supervised. Yet there is very little research that directly assesses whether supervision enhances client outcome. There is a small and growing

area of research indicating that clients of therapists receiving supervision have more positive outcome in therapy (Bambling et al., 2006). Clients whose therapists were being observed live by their supervisor (as opposed to reviewing recordings) had stronger working alliances with their therapist and better perception of therapy (Kivlighan, Angelone, & Swafford, 1991). It is also well-documented that "supervision improves supervisee emotional well-being, awareness of the therapeutic process, and confidence in their therapeutic ability" (O'Donovan, Halford, & Walters, 2011, p. 106).

In terms of the relationship of supervision to patient outcome, Watkins (2011) analyzed 18 studies on supervision-patient outcome published between 1981 and 2006. He concluded that after 30 years of research, it would be premature to make any conclusion as to whether supervision affects patient outcome. Adcock, Callahan, Aubuchon-Endsley, and Connor (2012) comment that "supervisors impact client outcome … generating a moderate effect size due, in part to individual supervisor differences (Callahan, Almstrom, Swift, Borja, & Heath, 2009) or training clinic policies on supervision (Cukrowicz et al., 2005)" (p. 23).

Conclusion

It is assumed that clinical supervision is an important component in the development of psychotherapists and psychologists. Yet from the results of the research on supervision, very little can be concluded about the way supervision can aid the development of psychotherapists and psychologists. The research thus far has been in the nature of surveys, and at best, evaluative research. The data analyzed were often limited to verbal reports from supervisees and supervisors.

The author echoes Watkins' (2012) recommendation that for the field of supervision to develop, it needs qualitative research to provide the substance of the supervisory experience, quantitative research to test hypotheses, and new instruments to measure the development of supervisors. As for quantitative research, this should include not only between groups research but also within groups research.

One area of research is the experience of supervision by both the supervisor and the supervisee. Neglected in the current literature is the impact of the "interior experience" on the developing supervisor (Watkins, 2012, p. 46). Of particular interest would be how a supervisee progresses internally in terms of thoughts, feelings, and motivation from a beginning supervisee to an advanced supervisee. That is, we need to know how supervision helps a beginning therapist become a therapist in his or her own right. Similarly, we need to know how a beginning supervisor advances to become an advanced supervisor. A related research topic could be how self-agency on the part of the supervisee, that is assuming responsibility for their own development, impacts the effects of clinical supervision. To address the questions about supervision, it would be helpful at this early stage in research to conduct a qualitative study of outstanding supervisors and supervisees in terms of their experiences and viewpoints regarding supervision. In all of this, it is important to differentiate between being a psychotherapist and the methods used to help one become a psychotherapist. To accomplish this, it is essential that the supervisor be a psychotherapist and design methods and techniques to help another become a psychotherapist.

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APPENDIX A

Supervision Competencies Framework Falender et al. (2004)

Knowledge

1. Knowledge of area being supervised (psychotherapy, research, assessment, etc.)
2. Knowledge of models, theories, modalities, and research on supervision
3. Knowledge of professional/supervisee development (how therapists develop, etc.)
4. Knowledge of ethics and legal issues specific to supervision
5. Knowledge of evaluation and process outcome
6. Awareness and knowledge of diversity in all of its forms

Skills

1. Supervision modalities
2. Relationship skills, including the ability to build supervisory relationship/alliance
3. Sensitivity to multiple roles with supervisee and ability to perform and balance multiple roles
4. Ability to provide effective formative and summative feedback
5. Ability to promote growth and self-assessment in the trainee
6. Ability to conduct own self-assessment process
7. Ability to assess the learning needs and developmental level of the supervisee
8. Ability to encourage and use evaluative feedback from the trainee
9. Teaching and didactic skills
10. Ability to set appropriate boundaries and seek consultation when supervisory issues are outside domain of supervisory competence

11. Flexibility
12. Scientific thinking and the translation of scientific findings to practice throughout professional development

Values
1. Responsibility for client and supervisee rests with the supervisor
2. Respectful
3. Responsible for sensitivity to diversity in all its forms
4. Balance between being supportive and challenging
5. Empowering
6. Commitment to lifelong learning and professional growth
7. Balance between clinical and training needs
8. Value ethical principles
9. Commitment to knowing and utilizing available psychological science related to supervision
10. Commitment to knowing one's own limitations

Social Context Overarching Issues
1. Diversity
2. Ethical and legal issues
3. Developmental process
4. Knowledge of the immediate system and expectations within which the supervision is conducted
5. Awareness of the sociopolitical context within which the supervision is conducted
6. Creation of climate in which honest feedback is the norm (both supportive and challenging)

Training of Supervision Competencies
1. Coursework in supervision including knowledge and skill areas listed
2. Has received supervision of supervision including some form of observation (videotape or audiotape) with critical feedback

Assessment of Supervision Competencies
1. Successful completion of course on supervision

2. Verification of previous supervision of supervision documenting readiness to supervise independently
3. Evidence of direct observation (e.g., audiotape or videotape)
4. Documentation of supervisory experience reflecting diversity
5. Documented supervisee feedback
6. Self-assessment and awareness of need for consultation when necessary
7. Assessment of supervision outcomes (both individual and group)

APPENDIX B

Supervisor-Supervisee Contract: Institution (Reproduced from Saint Paul University, Ottawa, Ontario, 2018)

Student: _____

Clinical supervision period (Dates): _____

Clinical supervisor: _____

General description

Clinical Supervision is considered by many to be the most valuable learning experience of this program; the collaboration with your clinical supervisor and your colleagues about your client work creates the opportunity for awareness, insight, and competency growth in your clinical skills. Clinical Supervision is a mandatory part of your practicum in the Master of Arts and PhD in Counselling and Spirituality, and is generally conducted in a group format on a weekly basis. (Please note that the first Clinical Supervision meeting each month will be conducted individually. The remaining Clinical Supervision meetings will be in the group format.) Each counselling intern in your group will present his/her client(s) (e.g. discussing interventions used, countertransference, transference, etc.) during clinical supervision.

You will contribute the most to clinical supervision by offering questions and suggestions that are relevant for conceptualization and treatment of each case presented. This will be done collaboratively with each group

member and the clinical supervisor. That being said, it must be recognized that the clinical supervisor holds direct responsibility for the welfare of the client and has the right to instruct you to directly address an issue (e.g., suicide assessment) with a client.

You must comply with such requests from your clinical supervisor to ensure the best care is provided for your client.

Your clinical supervision goals:

- Understand the key elements of an intake interview and put them into practice;
- Learn how to write succinctly (clinically relevant details only) and integrate an intake report that contains the important elements of the initial interview;
- Learn and master the theories of the approach presented by your clinical supervisor and clinical professor(s);
- Learn and master the various tools / techniques used in clinical supervision by consulting articles and manuals and by practicing with your colleagues;
- Develop a good therapeutic alliance with your client, being aware of your limits as a professional, the boundaries of your role in the therapeutic process, and by respecting your client's limits;
- Learn the basics of keeping a professional file (e.g., organization of the file, writing and editing the progress notes, sessions, etc.);
- Learn to prepare and review your file(s) for the semester review that may occur at any time during the semester;
- Ensure proper and punctual monitoring with your file and promptly notify your clinical supervisor of serious problems with your client or yourself (e.g., health problems can interfere with your work);
- Demonstrate an understanding of ethics and standards of professional behaviour;
- Participate actively and appropriately in clinical supervision by developing and maintaining a spirit of collaboration with your

colleagues and clinical supervisor; and
- Recognize your strengths and weaknesses and do not hesitate to discuss them when appropriate.

What we expect of you: Preparation for and during clinical supervision

- Be punctual and present for clinical supervisions;
- Being prepared is essential in order to fully benefit from clinical supervision (e.g., progress notes written, client recording preparation, etc.);
- Be respectful of your colleagues, your clients, your colleagues' clients, and your clinical supervisor to create a climate of collaborative clinical supervision and support;
- Be conscious / concerned with the ethics and standards of professional behaviour (including professional attire) and how they manifest themselves in your clinical work at many levels;
- Be self-reliant and independent in your work without compromising important aspects related to professional ethics (e.g., confidentiality, dual relationships, etc.);
- Consult your clinical supervisor when you are facing challenges, or have questions that you cannot solve alone;
- Keep all work related to your client strictly confidential. Client information is never to be communicated through e-mail;
- Present taped recordings of your client sessions to your clinical supervisor on a regular basis. You are required to show, at a minimum, a recording of each of your clients every two weeks. In the event that you do not have a recording of a client session to present in clinical supervision, you must record a role-play with a colleague(s) to present as an alternative; and
- Have timesheets signed by your clinical professor and clinical supervisor and submitted to the Counselling and Psychotherapy Centre administrative staff by the beginning of the following month (e.g. May timesheet due June 15).

What we expect of you: Attendance and holidays

- Absences are only accepted if they are justified for medical reasons or death (if you miss more than two clinical supervision meetings without justifiable explanation you automatically fail the practicum); and
- You are permitted to be away (holidays) up to three weeks during the Spring/Summer semester and two weeks during the Fall or Winter semesters. You are not permitted to take holidays during the evaluation period of each semester. Please note that holidays away from client work with the Counselling and Psychotherapy Centre does not mean that you are excused from your commitment to the mandatory attendance with your coursework.

Cell phones, laptops, and others

- Cell phones are strictly prohibited during clinical supervision and you are not allowed to leave clinical supervision to make calls or take calls.
- Laptop computers are allowed only if they are used to take notes in clinical supervision (e.g., how to run an intake interview, etc.). If you are writing emails, personal notes, or working on your documents for other courses, your computer will have to stay closed.
- Other technologies (iPod, electronic games) are prohibited in clinical supervision.

Other rules created by the clinical supervisor, with the student:

1. _____
_____
2. _____
_____
3. _____
_____
_____

My clinical supervision learning goals are:

1. _____

_____

2. _____

_____

3. _____

_____

_____

Clinical Supervisor's signature: _____

Student's signature: _____

Date signed: _____

NOTE: One copy of this contract is for the student and one copy is for the student's file at the Counselling and Psychotherapy Centre. The clinical supervisor may also wish to keep a copy of this contract.

APPENDIX C

Supervisor-Supervisee Contract: Private Practice (Augustine Meier, 2019)

This agreement is between _____ RP, and Member of the College of Registered Psychotherapists of Ontario (hereafter known as the Supervisor) and _____ (hereafter known as the Psychotherapist).

Psychotherapist: Tel # _____ Email address _____

This agreement is to provide supervision to the psychotherapist to enable him or her to meet the registration requirements of the College of Registered Psychotherapists of Ontario (CRPO). Within this context, the supervisor engages with a psychotherapist to promote his/her professional growth, enhance his/her safe and effective use of self in the therapeutic relationship, discuss the direction of therapy, and safeguard the well-being of the client. The psychotherapist is expected to practice within his/her area of competency that is determined by theoretical formation, training, and supervision. This agreement will take effect on the day that both the supervisor and psychotherapist sign the agreement.

1. The psychotherapist will provide a resumé of such background, training, education, and experience to appropriately present his/her competence for the particular clients they see. The psychotherapist will also participate in ongoing professional education activities as required by their regulatory body and special professional workshops suggested by the supervisor. The psychotherapist acknowledges that she/he has

read and will adhere to the Code of Ethics and the Professional Practice Standards for Registered Psychotherapists of the College of Registered Psychotherapists of Ontario.

2. Each year on the month and day that the first contract was signed, the psychotherapist will provide a copy of her/his liability insurance policy.

3. The psychotherapist will provide such documentation (e.g., Intake Report) to the supervisor so that there may be adequate planning for the effective delivery of services. The presentation of such documentation, when signed by the psychotherapist and supervisor, will signify the commencement of this agreement with that particular client. The psychotherapist will, as well, provide a list of his/her clients under the supervision of the supervisor, at the beginning of each scheduled supervision.

4. The progress of the work will be monitored through regular supervision (normally every four to six weeks, and/or every four sessions with the client) to ensure that the professional responsibility assumed by the supervisor can be carried out. The competencies of the psychotherapist and the complexity and urgency of the client's problem may require further supervision. The supervisor will be available for emergency consultation and intervention. Periodic supervision may take place in the office of the psychotherapist to ensure better knowledge and appreciation of the psychotherapist's professional milieu.

5. At the onset of service provision, the client will be informed of the following:
   a) The professional status, qualifications, and functions of the psychotherapist providing the service;
   b) That all services are reviewed with and conducted under the supervisor;
   c) The identity of the supervisor and how he/she can be contacted;
   d) That the supervisor has access to all relevant information about the client; and

e) That meetings with the supervisor can be arranged at the request of the client, supervisor, and/or psychotherapist.

6. Clients coming under this supervisor-psychotherapist agreement will be informed of the following:
   a) The supervisor's name, status, and qualification;
   b) The psychotherapist's regular supervision by the supervisor;
   c) The possibility of periodic meetings at the (1) supervisor's request, (2) psychotherapist's request, or (3) client's request; and
   d) That clinical records (written and/or electronic) will be safely stored under lock and key by the psychotherapist.
7. The supervisor and the psychotherapist may also work out other arrangements for necessary face-to-face sessions with clients, such as conjoint therapy and video presentation.

8. All written reports, case notes, and communications requested or required by third parties including but not limited to lawyers, the courts, organizations, and insurance companies will be discussed with the supervisor before the psychotherapist takes any action. Psychotherapy reports prepared by the psychotherapist are to be counter-signed by the supervisor. Fees received for such reports belong to the author of the report but are shared if the report is prepared conjointly by the psychotherapist and the supervisor.

9. Clients will pay the psychotherapist the agreed upon fee which will be receipted by the supervisor if the insurance company will not cover the services of the psychotherapist under supervision but will cover the services of the supervisor. All client receipts under this agreement will be in the name of the supervisor and signed by the psychotherapist. The psychotherapist will keep such financial records so that these receipts can be accessed by the supervisor if required for any investigation of the supervisor such as government audit or accountability inquiry by the College of Registered Psychotherapists of Ontario.

10. The psychotherapist agrees to pay the supervisor the following fees: (a) for one-on-one sessions: $xxx per 50-minute supervision, and (2) for two or more supervisees per meeting: $xxx per 50-minute supervision. Fees may be paid in cash or by cheque, major credit cards, or e-transfers.

11. On all advertising including webpages, brochures, pamphlets, and the like, the psychotherapist will indicate that his/her practice is under the supervision of the supervisor and provide the name and contact number for the supervisor.

12. If the supervisee has any college complaints or reports against her or him or has been charged criminally, he or she must immediately advise the supervisor of the complaints and/or the charges.

13. If the supervisee has a concern about the services provided by the supervisor, he or she is to discuss them with the supervisor. If the supervisee's concerns are not satisfactorily addressed, he or she may contact the:

    College of Registered Psychotherapists
    375 University Avenue, Suite 803
    Toronto, Ontario, M5G 2J5
    Tel: 1-844-712-1304 or 1-416-479-4330
    Email: info@crpo.ca

14. The agreement may be terminated by either party without cause upon 30 day's notice.

Agreement

I _____ have carefully read the Supervisor-Psychotherapist Contract and discussed it with the supervisor. I agree with the contractual arrangement.

_____ _____

Supervisor Psychotherapist

_____

Date

APPENDIX D

Supervisor's Appraisal Form – Private Practice

Instructions

When forms are not available to evaluate a psychotherapist's performance, the supervisor may develop his/her own form or use the following Supervisor's Appraisal Form or a variant of it.

The Supervisor's Appraisal Form consists of ratings of the supervisee's professional performance, ratings for core competencies, record of professional activities, and record of supervision contacts. The form also includes a statement about the supervisee's key strengths/assets and his/her limitations and liabilities and how they are to be addressed. The goals of supervision are also indicated.

It is good practice for the supervisee and the supervisor to complete the form independently and then to discuss their ratings and arrive at a single rating. It is also good practice for the supervisor to explain his or her ratings when there is a difference between his or her ratings and those of the supervisee.

It is important that the supervisor discuss with the supervisee the Appraisal Form and that both agree to its contents and procedures. Together they determine how often the Appraisal Form is to be completed. For example, is it to be completed once every three months, or once every four months?

The Appraisal Form is intended for the supervisor and supervisee and is to be kept in the supervisee's file. It is released to third parties only with the

authorization of the supervisee.

Institute for Self-in-Relationship Psychotherapy
Ottawa, Ontario

Appraisal Form*

Due Date _____

Name of Candidate: _____

Name of Supervisor: _____

Nature of relationship of candidate to supervisor (Please clearly specify):

_____

Domain of competency:

_____

_____

This report is based on the period from: _____ to _____

Total number of hours of clinical practice worked under supervision:

_____

If supervision of the candidate was interrupted during this period, please explain (e.g., illness).

_____

_____

_____

_____

*Adapted from Appraisal Form, College of Psychologists of Ontario

Supervisor's Appraisal Form

Topics Addressed During Supervision (Circle one value)

(Supervisor and supervisee discuss the extent to which they were addressed)

Supervisor and Candidate have:	Not Addressed				Fully Addressed
Engaged in detailed feedback/discussion regarding assessment and reports	1	2	3	4	5
Engaged in discussion of ethical and professional issues	1	2	3	4	5
Engaged in discussion of jurisprudence (law) in relation to practice	1	2	3	4	5
Ensured that candidate has had exposure to a relevant range of client populations	1	2	3	4	5
Ensured that candidate has had exposure to a wide range of problems	1	2	3	4	5
Engaged in discussion to identify candidate's strengths and areas that need improvement	1	2	3	4	5

Rating of Professional Performance*

(Supervisor and supervisee discuss the degree to which they are mastered)

General awareness/knowledge of jurisprudence	U	A	R
Competency in the supervised areas	U	A	R
Competency in formulating a conceptualization	U	A	R
Awareness of limits of competency	U	A	R
General maturity of professional attitude	U	A	R

U = Unacceptable; A = Acceptable; R = Ready for autonomous practice

Rating of Core Competencies and Professional Performance

Abilities/Interventions/Competencies	U	A	R
1. Provides a safe, secure, and trusting therapeutic environment			
2. Effective use of attending and interviewing skills			
3. Effective use of empathic responses			
4. Engages the client in the process			
5. Structures therapy session			
6. Does therapy in the here-and-now			
7. Adequately uncovers problem before moving towards treatment			
9. Links clinical material to theoretical constructs			
10. Ability to identify self and relational issues			
11. Identifies unmet self, relational, and physical intimacy needs			
12. Links client's current experiences to childhood experiences			
13. Clearly conceptualizes the case			
14. Identifies the working phase of the change process			
15. Clearly articulates short-term and long-term treatment plans			
16. Able to work with transference			
17. Recognizes and manages countertransference			
18. Able to constructively use countertransference			
19. Appropriate choice of therapy technique			

Abilities/Interventions/Competencies	U	A	R
20. Effective use of therapy technique			
21. Aware of his/her limitations			
22. General maturity of professional attitude			
23. Awareness of ethics and standards			

U = Unaccep table; A = Acceptable; R = Ready for autonomous practice

Statement of Candidate's Key Assets

Statement of Candidate's Limitations and Liabilities and How They are Addressed

Goals of Supervision

1. What were the main goals for this period of supervision?

2. To what extent were the goals achieved?

Record of Professional Activities During this Period

Professional Activities	Number	Hours
Psychotherapy – individual		
Psychotherapy – couple		
Psychotherapy – family		
Workshops presented		
Workshops attended		
Conferences – papers presented		
Conferences – attended		
Professional training		
Professional reading		
Other:		
Other:		

Supervisor and Supervisee Statements Regarding this Period of Supervision

Supervisor's Statement	Candidate's Statement
I have shown all of my evaluations and comments with the candidate and discussed them with her/him.	My supervisor has shown me all of his/her evaluations and comments and discussed them fully with me.
Name (Please Print):	Name (Please Print):
Signature:	Signature:
Date:	Date:

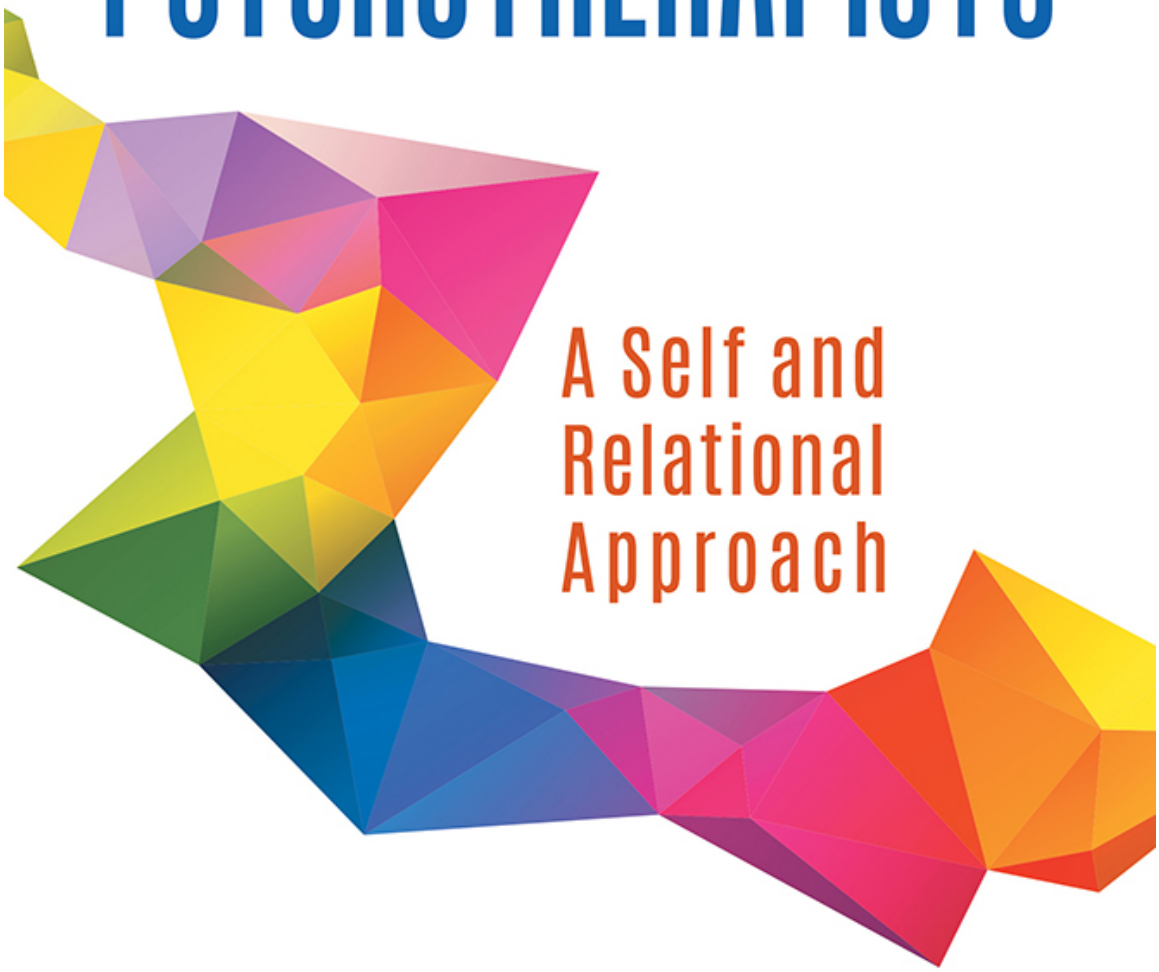
Record of Supervision Contacts

For Period Beginning _____ Ending _____

Candidate _____ Supervisor _____

Date	**Time Spent**	**Nature of Contact with Supervisor** (Cases, topics and issues discussed)	**Both Signatures**

Practical Clinical Supervision for PSYCHOTHERAPISTS



A Self and Relational Approach

AUGUSTINE MEIER